Electronically Delivered

November 2, 2022

Administrator
Ingleside
2811 Roland Avenue
Fairmont, MN 56031

RE: Project Number(s) SL30245015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 13, 2022, 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.

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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that

consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests 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

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,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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0 000	Initial Comments 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: SL30245015 On October 10, 2022, through October 13, 2022, 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 37 residents; 35 of whom were receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 10, 2022, at 10:30 a.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2023; however, LALD-A's license lacked an organization listed as the Director of Record for the licensee. On October 11, 2022, at 2:49 p.m. LALD-A reviewed the BELTSS website and confirmed she was not listed as the director of record and further stated she hadn't realized she needed to add that.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 had the potential to affect all 37 current residents 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 resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 480		

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0 480	Continued From page 3 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 October 11, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term	0 550		

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0 550	Continued From page 4 Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, the notice lacked the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health And Developmental Disabilities, and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On October 10, 2022, at approximately 10:00 a.m. the surveyor observed the licensee's grievance procedure posted at the main entrance. However, the posted information lacked the above content as required. On October 10, 2022, at 1:10 p.m. licensed assisted living director (LALD)-A confirmed the content noted above was not posted as required and was not aware it was missing from the	0 550		

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0 550	Continued From page 5 posted grievance procedure. The licensee's Complaint/Grievance policy dated October 5, 2021, noted the written notice would include: - the name and contact information of the person representing the facility designated to handle and resolve complaints - the contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5).	0 620		

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0 620	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R5's Individualized Abuse Prevention Plan dated September 30, 2022, indicated the resident used a walker for ambulation and had a history of falling. R5's progress note dated October 2, 2022, at 10:23 a.m. indicated staff called writer at 3:30 a.m. and reported they had received a phone call stating the R5 was down the street and unable to figure out how to get back to the building. The caller reported that R5 did not have her walker with her and seemed very confused. The staff picked R5 up and brought her back to the building, assisted in finding her walker and changing her clothes. The staff assisted R5 into bed. The writer contacted [family member] this morning and notified her of the incident. The writer also added one-hour checks for R5's safety. During the entrance conference on October 10, 2022, at 12:37 p.m. licensed assistant living director (LALD)-A indicated approximately one	0 620		

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0 620	Continued From page 7 week prior, they had a resident (R5) randomly walk out of the building. LALD-A stated they were having a meeting with the family at 1:30 p.m. today to create a corrective action plan and further stated they had already implemented interventions to keep the resident safe. When asked if the licensee had reported the incident to MAARC, LALD-A stated, "No, should I have?" The licensee's Vulnerable Adult Maltreatment Policy revised October 11, 2021, indicated: 4. Reporting Maltreatment a. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident medicate to their Assisted Living Director and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect, or financial exploitation, assisted living director/Registered Nurse will immediately make a report to the CEP (Common Entry Point). "Immediately" means as soon as possible, but no longer than 24 hours from the time the assisted living director/Registered Nurse received initial knowledge that the incident occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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

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0 810	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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 October 12, 2022, at approximately 10:20 a.m. with Licensed Assisted Living Director (LALD)-A and Operations Manager (OM)-F 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. During interview, LALD-A and OM-F 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, LALD-A and OM-F 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 it initial hire. During interview, LALD-A and OM-F	0 810		

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0 810	Continued From page 10 stated that training was provided annually per policy to employees after orientation. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, LALD-A and OM-F stated that the facility did not have documentation or a policy on offering resident training of the fire safety and evacuation plan. 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 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; (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	01060		

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01060	Continued From page 11	01060		

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.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (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 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:

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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 R2 was admitted to assisted living services on October 28, 2021. R2's Service Plan dated February 10, 2022, indicated R2 received the following services: medication administration, urinary catheter care, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming, housekeeping, and laundry. R2's progress notes dated September 3, 2022, at 5:19 p.m. indicated staff had called on-call registered nurse (RN) to report R2 had temperature of 100.6 Fahrenheit, shaking and red fluid in Foley (urinary catheter) bag. RN instructed staff to call 911 and have him sent to the emergency room. Progress notes dated September 3, 2022, at 8:32 p.m. indicated R2 had been transferred to a nearby hospital for admission. R2 returned to the facility on September 12, 2022, after his stay at the hospital. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - 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; - 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	01060		

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	30245	A. BUILDING: _____ B. WING _____	10/13/2022

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01060	Continued From page 13 may submit an appeal. In addition, R2's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On October 11, 2022, at 12:16 p.m. RN-B verified there was no written notice provided to R2, nor had the ombudsman been notified of R2's emergency relocation. RN-B was unaware of requirement. On October 11, 2022, at 3:25 p.m. licensed assisted living director (LALD)-A and operations manager (OM)-F stated they were unfamiliar with the requirement. The licensee's Contract Termination policy dated October 25, 2021, included in the event of an emergency relocation, [the licensee] would provide a written notice that contains, at a minimum: - the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -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 return date is not currently known; - a statement that, if the facility refuses to provide housing or series after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal. -the notice required will be delivered as soon as	01060		

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01060	Continued From page 14 practicable to: a. the resident, legal representative, and designated representative; b. for residents who receive home and community-based waiver services under the resident's case manager; and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	01380		

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01380	Continued From page 15 Based on observation, interview, and record review the licensee failed to ensure one of two unlicensed personnel (ULP-C) completed training and competency evaluations prior to providing direct cares as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C's employee record lacked evidence indicating the employee completed training and/or practical skills evaluations as required in the following areas prior to providing direct care services: - ambulation; - range of motioning and positioning. ULP-C started employment and began providing assisted living services on May 17, 2022. On October 11, 2022, at 8:40 a.m. ULP-C was observed physically assisting R3 with breakfast. On October 11, 2022, at 9:40 a.m. ULP-C and ULP-E was observed to transfer R3 from wheelchair into bed using a Hoyer (hydraulic total body lift). ULP-C's employee record lacked evidence of the above required topics. On October 13, 2022, at 9:30 a.m. registered	01380		

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01380	Continued From page 16 nurse (RN)-B verified the above topics were lacking from ULP-C's employee file. RN-B indicated the competency forms had been updated in the past year, and these two competencies must have been accidentally removed. The licensee's Assisted Living Orientation - ULP Staff policy dated October 8, 2021, noted training and competency evaluations of unlicensed personnel providing assisted living services will be completed by a registered nurse. In addition to training all staff receive, ULP who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: - ambulation - range of motion No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440		

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01440	Continued From page 17 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. 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 direct supervision for one of two unlicensed personnel (ULP)-C performing delegated nursing or therapy tasks within 30 days of first providing those 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 11, 2022, at 8:40 a.m. ULP-C was observed physically assisting R3 with breakfast. On October 11, 2022, at 9:40 a.m. ULP-C and ULP-E was observed to transfer R3 from wheelchair into bed using a Hoyer (hydraulic total body lift).	01440		

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01440	Continued From page 18 ULP-C was hired on May 17, 2022, to provide direct care services to residents at the assisted living. ULP-C's employee record lacked documentation of a RN supervising ULP-C performing delegated tasks within 30 days of beginning work with the licensee. On October 13, 2022, at approximately 9:30 a.m. RN-B confirmed ULP-C's employee file lacked a 30-day supervision of delegated tasks. RN-B verified ULP-C did delegated tasks and indicated the supervision form was on her desk and knew it needed to be completed. The licensee's Supervision of Unlicensed Personnel policy dated October 28, 2021, noted direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 19 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three residents (R1, R2, R3) service plans included all the required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01650		

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01650	Continued From page 20 R1 R1's service plan dated July 1, 2022, identified R1 received medication management services including blood sugar checks, assistance with bathing, dressing, laundry, and light housekeeping. R1's service plan lacked the following: - the frequency of each service, according to the resident's current assessment and resident preferences; - the schedule and methods of monitoring assessments of the resident; the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2 R2's service plan dated February 10, 2022, indicated R2 received the following services: medication administration, urinary catheter care, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming,	01650		

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01650	Continued From page 21 housekeeping, and laundry. R2's service plan lacked the following: - the frequency of each service, according to the resident's current assessment and resident preferences; - the schedule and methods of monitoring assessments of the resident; the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3's Service Plan dated February 17, 2022, indicated R3 received the following services: medication administration, blood sugar checks, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming, housekeeping, and laundry. R3's service plan lacked the following: - the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 22 - the schedule and methods of monitoring assessments of the resident; the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On October 12, 2022, at 1:23 p.m. operations manager (OM)-F confirmed the service plans did not indicate the frequency of all services and further confirmed did not include the schedule and methods of monitoring assessments of the resident; the schedule and methods of monitoring staff providing services; and a contingency plan that included all criteria as listed above. The licensee's Contents of Service Plans policy revised October 18, 2021, indicated: 5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments	01650		

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01650	Continued From page 23 e. Schedule and methods of monitoring staff providing services f. Contingency plan g. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wished to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on who has authority to sign for the resident in an emergency vi. Circumstances in which emergency medical services are not to be summoned No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01890 SS=E	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, interview, and record	01890		

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01890	Continued From page 24 review the licensee failed to ensure time sensitive medications were dated when opened for one of two residents (R6) with insulin, and two of three residents (R7, R8) with eye drops. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 11, 2022, at approximately 11:30 a.m. the surveyor observed the medication cart on the memory care unit with unlicensed personnel (ULP)-E. R6's Novolog FlexPen insulin pen lacked a date to indicate when staff opened it, or when it would expire. R7's Refresh tear eye drops lacked a date to indicate when staff opened it, or when it would expire. R8's lubricating eye drops lacked a date to indicate when staff opened it, or when it would expire. ULP-E confirmed the findings and verified insulin pens and eye drops should be dated when opened and when they would expire. On October 11, 2022, at 12:00 p.m. registered nurse (RN)-B confirmed all insulin and eye drops	01890		

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01890	Continued From page 25 should be dated when opened. RN-B further stated the licensee's practice was to throw them away after 28 days no matter if there was medication left in them or not. The Novolog FlexPen insulin manufacturer's instructions for use revised March 2021, noted: - The Novolog FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it. The licensee's Storage of Medication policy dated October 6, 2021, noted the medication must include the expiration date of time-dated drugs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02110 SS=F	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;	02110		

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02110	Continued From page 26 (4) medication management, including an assessment of residents for the use and effects 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 ensure policies and procedures required in assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for 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 the residents). The findings included:	02110		

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	30245	A. BUILDING: _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

(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
02110	Continued From page 27 The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R1, R2, and R3's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On October 11, 2022, at 2:49 p.m. licensed assisted living director (LALD)-A and operations manager (OM)-F confirmed they did not provide residents/legal representative or designated representative the dementia policies and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

(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
02110	Continued From page 28 procedures at the time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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03000	Continued From page 29 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Citation Text for Tag 0620, Regulation EF5D Buckholz, Wendy Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5). 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).	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

(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
03000	Continued From page 30 The findings include: R5's diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R5's Individualized Abuse Prevention Plan dated September 30, 2022, indicated the resident used a walker for ambulation and had a history of falling. R5's progress note dated October 2, 2022, at 10:23 a.m. indicated staff called writer at 3:30 a.m. and reported they had received a phone call stating the R5 was down the street and unable to figure out how to get back to the building. The caller reported that R5 did not have her walker with her and seemed very confused. The staff picked R5 up and brought her back to the building, assisted in finding her walker and changing her clothes. The staff assisted R5 into bed. The writer contacted [family member] this morning and notified her of the incident. The writer also added one-hour checks for R5's safety. During the entrance conference on October 10, 2022, at 12:37 p.m. licensed assistant living director (LALD)-A indicated approximately one week prior, they had a resident (R5) randomly walk out of the building. LALD-A stated they were having a meeting with the family at 1:30 p.m. today to create a corrective action plan and further stated they had already implemented interventions to keep the resident safe. When asked if the licensee had reported the incident to MAARC, LALD-A stated, "No, should I have?" The licensee's Vulnerable Adult Maltreatment Policy revised October 11, 2021, indicated:	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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03000	Continued From page 31 4. Reporting Maltreatment a. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident medicate to their Assisted Living Director and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect, or financial exploitation, assisted living director/Registered Nurse will immediately make a report to the CEP (Common Entry Point). "Immediately" means as soon as possible, but no longer than 24 hours from the time the assisted living director/Registered Nurse received initial knowledge that the incident occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/11/22*
Time: 11:25:02
Report: 1020221128

Food and Beverage Establishment Inspection Report

Location:
Ingleside
2811 Roland Avenue
Fairmont, MN56031
Martin County, 46

Establishment Info:
ID #: 0038478
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072389654
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

CHLORINE TEST STRIPS ARE EXPIRED. PURCHASE NEW CHLORINE TEST STRIPS FOR BOTH THE MAIN KITCHEN AND MEMORY CARE KITCHEN. USE AT LEAST 2 TIMES WEEKLY.

Comply By: 10/25/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

1) PART OF LAMINATE COUNTERTOP IN MAIN KITCHEN IS BROKEN; REPAIR.
2) LAMINATE SURFACE IS SEPARATING AND SHOWING WEAR ON THE FRONTS OF DOORS UNDER 2 BAY SINK IN THE MAIN KITCHEN; REPAIR.
3) BROKEN HANDLES ON CABINETS IN MAIN KITCHEN; REPLACE.

Comply By: 01/11/23

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: MAIN KITCHEN DISHWASHER
Violation Issued: No

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: MEMORY CARE KITCHEN DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *10/11/22*
Time: 11:25:02
Report: 1020221128
Ingleside

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: LASAGNA - STEAM TABLE, MAIN KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - WALK-IN FREEZER, MAIN KITCHEN

Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: TOMATO SOUP - WALK-IN COOLER, MAIN KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, MEMORY CARE KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: BUTTER - UPRIGHT COOLER, MEMORY CARE KITCHEN
Violation Issued: No

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

GENERAL COMMENTS:

DISCUSSED EMPLOYEE ILLNESS POLICIES AND PROCEDURES. ILLNESS REPORTING REQUIREMENTS FACT SHEET AND EMPLOYEE ILLNESS LOG PROVIDED WITH THE REPORT.

ALL FOOD IS PREPARED IN THE MAIN KITCHEN AND BROUGHT OVER TO MEMORY CARE BY CARTS. LEFTOVERS ARE NOT SAVED FOR LATER USE BY RESIDENTS AND ARE DISCARDED.

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 1020221128 of 10/11/22.

Certified Food Protection Manager: Melanie E. Anderson

Certification Number: FM105463 Expires: 02/02/24

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley R
Ashley B

651-201-4500

Report #: 1020221128

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	10/11/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:25:02
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Ingleside	2811 Roland Avenue	Fairmont, MN	56031	5072389654

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038478		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		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) Report emailed **Date:** 10/20/22

Inspector (Signature)