



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 23, 2024

Licensee
Asher Haus
717 1st Street North
Cold Spring, MN 56320

RE: Project Number(s) SL35636016

Dear Licensee:

On December 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 9, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Jessie Chenze'.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 14, 2024

Licensee
Asher Haus
717 1st Street North
Cold Spring, MN 56320

RE: Project Number(s) SL35636016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 9, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS		STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320			
(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: SL35636016-0 On October 7, 2024, through October 9, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 20 residents; all receiving services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on October 8, 2024, issued for SL35636016-0, tag identification 2310.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators ' 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 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS		STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320			
(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
0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 7, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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
0 630	Continued From page 2 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R6). 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 the potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included Alzheimer's Disease, anxiety disorder, monoclonal gammopathy (abnormal proteins in blood), dizziness, degenerative joint disease, and degenerative disc disease. R2's Addendum to Contract - Private - MN (Minnesota), identified as service plan, dated	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS		STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320			
(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
0 630	Continued From page 3 January 1, 2024, indicated R2 receiving services including behavior monitoring, meals, personal assistance, bathing, compression stockings, medication administration, safety checks housekeeping, and laundry. R2's IAPP, dated August 28, 2024, indicated R2 was at risk to be abused physically, verbally, emotionally, financially, and sexually. Also included, R2 had no history of attempted or thoughts of suicide, impaired judgement, difficulty using the phone, and difficulty communicating. R2's IAPP included statements of the specific measures to be taken to minimize the risk of abuse to R2. R2's IAPP failed to include: - the person's risk of abusing other vulnerable adults. R6 R6's diagnoses included dementia without behavioral disturbance, cognitive communication deficit, generalized anxiety, generalized weakness, difficulty with walking, osteoporosis. R6's Addendum to Contract - Private - MN, identified as the service plan dated June 13, 2024, indicated R6 received services including medication administration, medication reminders, activity assistance, ambulation, bathing assistance, compression stockings, bed mobility, dressing, grooming, mobility assistance, safety checks, transfer assistance, toileting, housekeeping and laundry. R6's IAPP, dated September 10, 2024, indicated R6 was at risk to be abused physically, verbally, emotionally, financially, and sexually, and had impaired judgement. R6's IAPP included statements of the specific measures to be taken to minimize the risk of abuse to R6. R6's IAPP	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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
0 630	Continued From page 4 failed to include: - the person's risk of abusing other vulnerable adults. On October 9, 2024, at 2:59 p.m., clinical nurse supervisor (CNS)-A stated the current electronic medical record did not include that question in the assessment, so they would be adding that to the assessment. CNS-A stated the same assessment was used for all residents. The licensee's Initial and On-going Assessments of Residents policy, dated 2021, indicated the comprehensive assessment included the requirements outlined by Minnesota rules, and would include an assessment of the resident ' s areas of vulnerability and susceptibility to maltreatment and whether the resident poses a risk to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
01060 SS=D	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	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS		STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320			
(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 5 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an 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	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS		STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320			
(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 6 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: R2's diagnoses included Alzheimer's Disease, anxiety disorder, monoclonal gammopathy (abnormal proteins in blood), dizziness, degenerative joint disease, and degenerative disc disease. R2's Addendum to Contract - Private - MN (Minnesota), identified as service plan, dated January 1, 2024, indicated R2 receiving services including behavior monitoring, meals, personal assistance, bathing, compression stockings, medication administration, safety checks housekeeping, and laundry. R2's progress notes indicated: - September 29, 2024, at 11:49 p.m., R2 was found on the floor in the apartment at 11:25 p.m., sitting next to the bed. The fall was unwitnessed and R2 could not describe what happened. R2 could not stand up straight and emergency medical services (EMS) were called. - September 30, 2024, at 12:30 a.m., EMS was on scene and taking R2 to the hospital to be evaluated. - October 1, 2024, at 4:28 p.m., R2 returned to the facility. R2's record lacked evidence of a written notice provided to the resident, legal representative, designated representative, and R2's case	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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 7 manager 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 and Office of Ombudsman for Mental Health and Developmental Disabilities; - 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 - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal, and will provide contact information for the agency to which the resident may submit an appeal. On October 9, 2024, at 1:04 p.m., clinical nurse supervisor (CNS)-A and corporate registered nurse (CRN)-F stated the licensee's Notice of Emergency Relocation was in duplicate, and as the resident was leaving the facility in an emergency situation, the form was completed and the yellow copy was given to the resident, and the original was kept for the nurse to review. CNS-A and CRN-F stated they weren't aware that they needed to provide the written notice to the legal representative and the designated representative, as required, and stated they were unable to locate R2's notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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
01290	Continued From page 8	01290			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of four employees (unlicensed personnel (ULP)-G). 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-G began employment on July 22, 2024, to	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS		STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320			
(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
01290	Continued From page 9 provide direct care for the licensee's residents. ULP-G's employee record contained a background study dated August 1, 2024, submitted through a separate location operated by the licensee's owner; however, ULP-G's employee record lacked evidence the licensee affiliated a background study for their assisted living license. On October 9, 2024, at 11:44 a.m., human resources (HR)-H stated ULP-G worked at other facilities that the licensee owned and stated ULP-G's background study from August 1, 2024, for the separate location was the only clearance the licensee obtained, until today. HR-H stated she did not realize that ULP-G's background study was not affiliated with the licensee until the surveyor requested it. HR-H presented an updated background clearance letter, dated October 9, 2024, affiliated with the licensee. The licensee's Background Checks policy, dated 2022, indicated all employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. The policy lacked direction that the background study must be affiliated with the licensee, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS		STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320			
(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
01790	Continued From page 10 is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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
01790	Continued From page 11 medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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 the potential to affect a large portion or all of the residents). The findings include:	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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
01790	Continued From page 12 During the entrance conference on October 7, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-A and registered nurse (RN)-B stated the licensee provided medication management services for the licensee's residents including medication administration and medication set up, and ULPs administered those medications after being trained by CNS-A. The licensee's Medication Management - Away from Home policy, dated 2021, indicated, for unplanned time away when the licensed nurse was not available, the registered nurse had trained the unlicensed staff and determined the unlicensed staff was competent to follow the procedures for giving medications to residents. The policy also included, "The unlicensed personnel follow the written procedures developed by the registered nurse specifically for unlicensed personnel, including any special instructions or procedures regarding controlled substances." On October 9, 2024, 10:30 a.m., ULP-D stated she was not aware of written procedures to follow when a resident left the facility and medications were provided. ULP-D stated she just "knew what to do," and documented this in the electronic medical record. On October 9, 2024, at 10:40 a.m., RN-B stated there were no written procedures for ULPs when providing medications to residents for unplanned time away from the facility, as directed in the licensee's policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS		STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320			
(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
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R6) with an assistive device. This resulted in an immediate order for correction on October 8, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 8, 2024, at 7:39 a.m., the surveyor observed R6's bed to have a single upside down squared U-shaped device, white metal with black gripper material across the top, with two metal bars black rubber stoppers that rested on the floor, on the left side of the bed. R6 was sitting in a chair, and unlicensed personnel (ULP)-E stated she had never observed R6 use the device. ULP-E lifted the single mattress for the surveyor	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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
02310	Continued From page 14 to observe how the device was attached/applied to the bed. The device was not attached to the bed in any way, but there were two metal bars, in the shape of a large rectangle, that slid under the mattress, the width of the single bed. A sticker on the device indicated the manufacturer of the device was "Vaunn." R6's diagnoses included dementia without behavioral disturbance, cognitive communication deficit, generalized anxiety, generalized weakness, difficulty with walking, osteoporosis. R6's Addendum to Contract - Private - MN, identified as the service plan dated June 13, 2024, indicated R6 received services including medication administration, medication reminders, activity assistance, ambulation, bathing assistance, compression stockings, bed mobility, dressing, grooming, mobility assistance, safety checks, transfer assistance, toileting, housekeeping and laundry. R2's Assessment dated September 10, 2024, indicated R6 had repetitive behavior and was severely cognitively impaired. The assessment also included, under Safety, an assessment of the assistive device, indicating the left sided device was in good condition, aided the resident in transfers to and from bed, and transitioning independently in/out of bed, was "Not an FDA [Food and Drug Administration] approved device," as it was "a consumer device with no manufacturer guide to review recalls and proper installation." R6 had cognitive impairments and was taking a medication for moderate to severe pain, and indicated the device as "needed to continue independently with bed mobility." Also included, education was provided to R6's responsible party and they voiced understanding,	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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
02310	Continued From page 15 and "Vaunn Medical bed rail installed according to manufacturer instructions. No known recalls." On October 8, 2024, at 9:01 a.m., the surveyor reviewed the Consumer Product Safety Commission (CPSC) Recalls website. The Vaunn device currently being utilized by R6 was recalled on March 9, 2023, due to "Serious Entrapment and Asphyxia Hazards." R6's Assistive Bed Device Risks and Benefits Acknowledgement Form Assisted Living dated February 19, 2024, indicated the device "DOES NOT meet FDA guidelines for safety because it does not meet the recommended bed rail measurements, or application and may have significant risk for harm due to entrapment, which has been known to cause injury or death. Therefore, I agree to the removal and I will discuss and consider alternative options offered to me." R6's Assistive Bed Devices Education Acknowledgement Form dated February 19, 2024, and signed April 12, 2024, indicated, "Potential risks of traditional bed rails, consumer devices, non-FDA approved devices, and devices in general." The education lacked information that the device had been recalled. On October 8, 2024, at 10:14 a.m. clinical nurse supervisor (CNS)-A and corporate registered nurse (CRN)-F stated the assistive device assessments were completed with the 90-day assessments in the electronic medical record, and initially an educational pamphlet was given to the resident's responsible party, as well as an acknowledgement of discussion of Risk versus Benefit of the device, and the nurse would seek out manufacturer's information and review the	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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
02310	Continued From page 16 CPSC website for recalls. When asked if the CPSC website was reviewed for R6's device as documented, CNS-A stated, "No." CNS-A stated other devices were offered to R6's responsible party; however, they chose to use this device. CNS-A stated R6's responsible party was not informed this device had been recalled due to serious entrapment and asphyxia hazards. On October 8, 2024, at 11:40 a.m., CRN-F stated they were in the process of working with R6's responsible party to determine how to keep R6 safe, and stated they reviewed the CPSC website for another assistive device being used by another resident, and that device was also recalled, so they would putting interventions into place for both residents. The licensee's Assistive Bed Devices policy dated 2023, indicated assisted bed devices would be used if the Assistive Bed Devices Assessment determined that the device was not a restraint, non-hospital beds with consumer assistive devices complied with the Consumer Product Safety Commission guidelines, was beneficial to the resident, and the community documented that the resident/responsible party desired the use of the device following discussion of the risks and benefits. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information."	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER ASHER HAUS			STREET ADDRESS, CITY, STATE, ZIP CODE 717 1ST STREET NORTH COLD SPRING, MN 56320		
(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	
02310	Continued From page 17 The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			



Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: 10/07/24
Time: 11:00:08
Report: 1041241229

Food and Beverage Establishment Inspection Report

Page 1

Location:

Asher Haus
717 1st Street North
Cold Spring, MN56320
Stearns County, 73

Establishment Info:

ID #: 0038027
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2306854110
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.

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

CLEAN MICROWAVE TO REMOVE FOOD BUILD UP.

Comply By: 10/08/24

Surface and Equipment Sanitizers

Hot Water: = at 174 Degrees Fahrenheit

Location: DISHWASHER FINAL RINSE CYCLE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 41 Degrees Fahrenheit - Location: MILK

Violation Issued: No

Process/Item: Hot Holding

Temperature: 154 Degrees Fahrenheit - Location: CHICKEN BREAST

Violation Issued: No

Process/Item: Hot Holding

Temperature: 173 Degrees Fahrenheit - Location: RICE

Violation Issued: No

Type: Full
Date: 10/07/24
Time: 11:00:08
Report: 1041241229
Asher Haus

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Hot Holding

Temperature: 154 Degrees Fahrenheit - Location: VEGETABLE RICE SOUP

Violation Issued: No

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

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 1041241229 of 10/07/24.

Certified Food Protection Manager: AMY SCHREIFELS

Certification Number: 120702 Expires: 10/28/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: Linda Heinen

Linda Heinen

Public Health Sanitarian

St. Cloud

320-223-7306

Linda.Heinen@state.mn.us

Report #: 1041241229		Food Establishment Inspection Report							
 Minnesota Department of Health Environmental Health Division 3333 W. Division #212 St. Cloud		No. of RF/PHI Categories Out		1		Date 10/07/24			
		No. of Repeat RF/PHI Categories Out		0		Time In 11:00:08			
		Legal Authority MN Rules Chapter 4626				Time Out			
Asher Haus		Address 717 1st Street North		City/State Cold Spring, MN		Zip Code 56320		Telephone 2306854110	
License/Permit # 0038027		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 Hygienic 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					
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 ☐ IN ☐ OUT				Water & ice obtained from an approved source					
32 ☐ IN ☐ OUT ☒ N/A				Variance obtained for specialized processing methods					
Food Temperature Control									
33 ☐ IN ☐ OUT				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 ☐ IN ☐ OUT				Thermometers provided & accurate					
Food Identification									
37 ☐ IN ☐ OUT				Food properly labeled; original container					
Prevention of Food Contamination									
38 ☐ IN ☐ OUT				Insects, rodents, & animals not present					
39 ☐ IN ☐ OUT				Contamination prevented during food prep, storage & display					
40 ☐ IN ☐ OUT				Personal cleanliness					
41 ☐ IN ☐ OUT				Wiping cloths: properly used & stored					
42 ☐ IN ☐ OUT				Washing fruits & vegetables					
Food Recalls:									
Person in Charge (Signature)									
Date: 10/08/24									
Inspector (Signature) Linda Zinen									