Electronically Delivered

December 15, 2023

Licensee
Risen Home Care LLC
5333 Bryant Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL37667015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

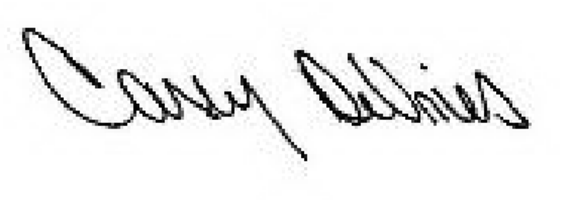
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37667	A. BUILDING: _____ B. WING _____	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN HOME CARE LLC	5333 BRYANT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: SL37667015-0 On November 27, 2023, through November 29, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three active residents; all of whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 1 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On November 27, 2023, at 10:30 a.m., the surveyor observed the common areas shared by residents, staff, and visitors, lacked the required	0 550		

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0 550	Continued From page 2 information for reporting suspected maltreatment to the MAARC. On November 27, 2023, at 10:30 a.m., licensed assisted living director (LALD)-C acknowledged the required information was not posted and available for residents, staff, and visitors. LALD-C stated, "No, I do not have that posted anywhere, but I can change it right away to have it posted." The licensee's undated Reporting Maltreatment of Vulnerable Adult policy read, "Posting information for reporting suspected crime and maltreatment. The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: 1) Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility 2) Posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and 3) Providing reasonable accommodations with information and notices in plain language i. Review, revise and implement service plan revisions and care plan interventions to reduce the likelihood of any future maltreatment of vulnerable adult ii. Review, revise and implement facility policies and procedures, as needed, to reduce the risk of future incidents." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 630	Continued From page 3	0 630		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the 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 address the resident's susceptibility to the risk of abuse to others for one of three residents (R2) receiving 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: R2 began receiving assisted living services from the licensee on April 4, 2023. R2's Resident Contract for Assisted Living was signed on April 19, 2023.	0 630		

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0 630	Continued From page 4 R2's Signed Service Plan dated April 19, 2023, indicated R2 required assistance with activities, bathing, dressing, grooming, housekeeping, laundry, behavior management, medication administration, meals, shopping assistance, and vitals. R2's record lacked an individualized review or assessment of the resident's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse to that resident or other vulnerable adults. On November 27, 2023, at 1:28 p.m., clinical nurse supervisor (CNS)-A stated, "It looks like that was just overlooked as everyone else has it completed." The licensee's undated Abuse Prevention Plans policy read, "All residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. This includes self abuse. The plan will be incorporated into the resident care plan and will reflect their ability to participate in and direct their own care in the presence of an identified caregiver." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 660	Continued From page 5	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of three employees, (clinical nurse supervisor (CNS)-A, and unlicensed personnel (ULP)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 660		

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0 660	Continued From page 6 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: CNS-A CNS-A began employment with the licensee and started providing assisted living services February 23, 2022. On November 27, 2023, at approximately 9:15 a.m., the surveyor observed CNS-A working for the licensee during the entrance conference. ULP-B ULP-B began employment with the licensee and started providing assisted living services August 16, 2022. On November 27, 2023, at approximately 11:07 a.m., the surveyor observed ULP-B assisting residents with laundry. CNS-A and ULP-B's employee records lacked evidence of screening for active TB with either a two-step TST or blood test. On November 27, 2023, at 2:05 p.m., licensed assisted living director (LALD)-C stated, "We always send employees out to get the blood test but it was paused during covid so I will have to check why his wasn't done." The licensee's undated Employees at Risk for Exposure or Who Have Been Exposed to TB policy, read, "[Licensee] will establish a protocol for early identification of individuals with active tuberculosis. The Risen Home Care will, at no	0 660		

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0 660	Continued From page 7 cost to the employee, offer TB Mantoux skin test or a blood test at the time of employment, annually (if needed) and as indicated in situations of TB exposure. Employees who can show evidence of a negative Mantoux within three months prior to hire date may use that test as step one of two step test at the time of employment. Employees who have documentation of a negative blood test or a negative Chest X-ray within three (3) months of employment do not need to have it repeated." The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 8 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - establish/maintain a comprehensive emergency preparedness (EP) which describes the facility's	0 680		

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0 680	Continued From page 9 approach to mtg health/safety/security needs of staff/residents; - address how would coordinate the community on a whole during emergency or disaster (natural, man-made, facility, etc.); - be updated annually, must document date of review and any updates made to the plan based on the review; - have a risk assessment that considers hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing facility & community-based risks; - address the following whether evacuated or shelter in place for staff/residents: - food, water, medical supplies, pharmaceutical supplies; - alternate sources of energy to maintain: - temperatures to protect resident health/safety; - safe/sanitary storage of provisions; - emergency lighting; - fire detection, extinguishing, alarm systems; and - sewage and waste disposal; - develop policy or procedure for system to track the location of on-duty staff and sheltered residents; - develop policy or procedure for use of volunteers, including the process/role for integration; - develop policy or procedure for to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -have a communication plan must include all of the following: method for sharing information from	0 680		

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0 680	Continued From page 10 the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - must develop and maintain EP training and testing program; - conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP; -must include the following: -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On November 28, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated "I know we are missing some of the items, like I know I don't have that 1135 act one, because I am going to need to look up what that actually is." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss,	0 700		

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0 700	Continued From page 11 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all the resident's personal health and medical information was kept private. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, from 1:17 p.m. to 1:25 p.m., the surveyor observed an unattended medication cart for eight minutes with an unlocked computer screen used for accessing resident records for medications and treatments. The screen displayed all of the resident's full names and medication pass times. The surveyor observed two other staff pass directly by the unattended laptop. On November 28, 2023, from 8:55 a.m., to 9:04 a.m., the surveyor observed an unattended medication cart for nine minutes with an unlocked	0 700		

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0 700	Continued From page 12 computer screen used for accessing resident records for medications and treatments. The screen displayed all of the facilities resident's full names and medication pass times. The surveyor observed two other staff and one resident pass directly by the unattended laptop. On November 28, 2023, at 9:31 a.m., clinical nurse supervisor (CNS)-A stated, "We make sure we train all the staff, because they need to know the consequences of violating HIPPA, so I spend hours training them on things like not leaving the computer with the screen up, and you can't speak about a client to other staff in front of other clients. My expectations are that everyone follow that and if they can't then I come back with re-training and if it continues then we move on to disciplinary action." The licensee's undated Resident Records policy read, "All resident information shall be regarded as confidential and available only to authorized users." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790		

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	37667	A. BUILDING: _____ B. WING _____	12/01/2023

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0 790	Continued From page 13 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have the required size fire extinguisher and provide required routine maintenance of fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on November 27, 2023, at 10:30 a.m., with licensed assisted living director (LALD)-C it was observed each of the fire extinguishers provided were 1-A:10-BC (size) rated and the facility did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. It was also observed the monthly inspections were not being completed for either fire extinguisher. The fire extinguisher (white) on the main level had a service tag dated September 2022 and the fire extinguisher (red) on the lower	0 790		

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0 790	Continued From page 14 level did not have a service tag. All fire extinguishers in the licensed facility must be properly maintained. The licensee failed to complete monthly and annual maintenance as required. On November 27, 2023, at 10:30 a.m., LALD-C verified the licensee had the incorrect size fire extinguishers and required maintenace was not completed. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide fire-rated ashtrays for resident use in smoking areas. 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 was issued at a widespread scope (when	0 800		

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0 800	Continued From page 15 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on November 27, 2023, at 10:30 a.m., with licensed assisted living director (LALD)-C, it was observed the main level wooden deck was being used as a smoking area for residents. The smoking area was immediately adjacent to the living room and sitting room windows. There was a gallon size metal paint can filled with cigarette butts sitting on the deck floor as well as a clay ashtray filled with cigarette butts sitting on the wooden guardrail of the deck. There were additional cigarette butts located inside some of the damaged deck boards. During interview on November 27, 2023, at 10:30 a.m., LALD-C stated residents would smoke on the deck and use the paint can and ashtray to extinguish and discard their cigarette butts. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and the discarded cigarette butts were a potential fire hazard if the cigarettes were not completely extinguished before discarding them. LALD-C stated she understood the risks of not having a fire-rated ashtray in the smoking area and would provide one. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 16 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all	0 810		

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0 810	Continued From page 17 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 potential to affect a large portion or all of the residents). The findings include: On November 28, 2023, licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP, titled "Fire Safety Program for the Facility", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronyms R.A.C.E. (Remove, Alarm, Confine and Extinguish or Evacuate) and P.A.S.S. (Pull, Aim, Squeeze, and Sweep) but failed to include procedures for how staff are to complete each step. The plan also inappropriately included maintenance requirements for a fire suppressant sprinkler system which the facility did not have in place at the time of the survey.	0 810		

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0 810	Continued From page 18 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on November 29, 2023, at 12:30 p.m., LALD-C stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-C was unable to provide documentation showing any training offered to residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evidenced by the "knowledge assessment" provided by an online third-party platform. LALD-C was unable to provide documentation showing required training on facility-specific plans. One in-person staff training on the facility-specific plan was completed on 10/06/2023. No other documentation was provided.	0 810		

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0 810	Continued From page 19 During an interview on November 29, 2023, at 12:30 p.m., survey staff explained to LALD-C staff are required to be trained on the facility-specific fire safety and evacuation plan. Generic fire safety training that is not specific to the facility does not meet requirements. LALD-C stated she understood the areas of her training that were insufficient and would work on bringing them into compliance. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evidenced by the fire drill reports provided. Evacuation drills were conducted on 03/11/2022, 09/27/2023, and 10/06/2023. No other documentation was provided. During an interview on November 29, 2023, at 12:30 p.m., LALD-C stated there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management	0 900		

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0 900	Continued From page 20 agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content prior to the start of services for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 900		

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0 900	Continued From page 21 The findings include: R2 moved in and began receiving assisted living services from the licensee on April 4, 2023. R2's Resident Contract for Assisted Living was signed on April 19, 2023, indicating 15 days had passed from date of move in, prior to receiving a signed contract. R2 did not receive the required post 144G Statute contract to be provided to residents prior to providing housing or assisted living services. On November 27, 2023, at 1:00 p.m., licensed assisted living director (LALD)-C stated, "I know we sent her [R2] contract to be signed but they didn't sign it right away, I will look for the email or where we documented that we sent it before that date and if I can find it, I will get it to you." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	0 950		

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0 950	Continued From page 22 "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 began receiving assisted living services from	0 950		

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0 950	Continued From page 23 the licensee on April 4, 2023. R2's Resident Contract for Assisted Living was signed on April 19, 2023. R2's Resident Contract for Assisted Living included an area to designate a representative but lacked the verbatim "right to designate a representative for certain purposes" notice. On November 27, 2023, at 12:00 p.m., licensed assisted living director (LALD)-C stated "Everyone gets the same contract, I was unaware we needed to have that with certain wording. We can get that changed." The licensee's undated Assisted Living Contracts policy read, "Clients have the right to designate a representative before they sign a contract. The facility must offer the resident the opportunity to identify a representative in writing on the contract and must provide the following notice on a document separate from the contract: a. RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. "You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact") or health care power of attorney ("health care agent"), if applicable. b. The contract must contain a page or space for the name and contact information of the Designated Representative and a box the resident must initial if they decline to name a representative. The resident has the right to add,	0 950		

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0 950	Continued From page 24 remove, or change the name and contact information of the Designated Representative at any time." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
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 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	01060		

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01060	Continued From page 25 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 to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3's unsigned Service Plan printed November 27, 2023, indicated R3 required assistance with	01060		

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01060	Continued From page 26 activities, bathing, deep room cleaning, dressing, grooming, housekeeping, laundry, behavior management, medication administration, nail care, meals, blood glucose monitoring, shopping assistance, and vitals. R3's services were on hold at the time of survey due to being at the hospital for cares. On November 27, 2023, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated, "He [R3] is currently in the hospital, he went in on November 20th." On November 27, 2023, at 11:45 a.m., when asked if the licensee had provided a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, as well as updated the OOLTC, CNS-A stated, "No I do not do that form. I am unaware of that form." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37667	A. BUILDING: _____ B. WING _____	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN HOME CARE LLC	5333 BRYANT AVENUE NORTH BROOKLYN CENTER, MN 55430

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01500	Continued From page 27 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500		

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	37667	A. BUILDING: _____ B. WING _____	12/01/2023

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01500	Continued From page 28 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-B). 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: ULP-B began employment with the licensee and started providing assisted living services August 16, 2022. On November 27, 2023, at approximately 11:07 a.m., the surveyor observed ULP-B assisting residents with laundry. ULP-B's record lacked evidence annual training had been completed as required in the following areas: - Review of the assisted living bill of rights (BOR); - Infection control techniques; - Effective approaches to use to problems solve when working with a resident's challenging	01500		

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	37667	A. BUILDING: _____ B. WING _____	12/01/2023

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01500	Continued From page 29 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - Review of provider's policies and procedures; and - Dementia Training: Met two (2) hours annually. On November 28, 2023, at 9:34 a.m., clinical nurse supervisor (CNS)-A stated, "I go topic by topic and I go through everyone so in October or November everyone gets the annual training on time, but I don't have it documented the time spent on it or what we covered. I will make sure to document that going forward." The licensee's undated Annual Training Requirements policy read, "ANNUAL TRAINING MUST INCLUDE: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including: a. A review of hand-washing techniques b. Need for and use of protective gloves, gowns, and masks c. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades d. Disinfecting reusable equipment e. Disinfecting environmental surfaces f. Reporting of communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease or related disorders	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37667	A. BUILDING: _____ B. WING _____	12/01/2023

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01500	Continued From page 30 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

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	37667	A. BUILDING: _____ B. WING _____	12/01/2023

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01620	Continued From page 31 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents) The findings include: On November 27, 2023, at approximately 9:15 a.m., during the entrance conference clinical nurse supervisor (CNS)-A) stated ongoing assessment were completed every 90 days and with change of condition. R2 began receiving assisted living services from the licensee on April 4, 2023. R2's diagnoses included nicotine dependency, alcohol dependency, reflux disease, adult failure to thrive, major depressive disorder, pain in thoracic spine, altered mental status, unspecified, pain in left shoulder, pain in right shoulder, and unspecified dementia, with mood disturbance. R2's Signed Service Plan dated April 19, 2023, indicated R2 required assistance with activities,	01620		

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	37667	A. BUILDING: _____ B. WING _____	12/01/2023

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01620	Continued From page 32 bathing, dressing, grooming, housekeeping, laundry, behavior management, medication administration, meals, shopping assistance, and vitals. R2's record included nursing assessments dated April 19, 2023, August 7, 2023, and October 16, 2023. The assessment completed on August 7, 2023, indicated 1110 days had passed between assessments. On November 27, 2023, at 1:01 p.m., CNS-A stated, "I can tell you what happened, I had up to five residents that needed to be done so I did the assessments, but I did not get to chart them right away and with this system it doesn't mark complete until you sign them off, so they all look late. I don't always chart the same day I complete the face-to-face assessment." The licensee's undated comprehensive resident assessment policy, read, "On-going resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. All assessments will be included in the resident record. The registered nurse will update the assessment and service plan as needed when changes occur. This would include return to the facility following hospitalization or stay in a nursing facility or changes in condition that alter the plan of care." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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03090	Continued From page 33	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at approximately 9:00 a.m., the surveyor observed an electronic monitoring notice posted on the front door of the facility that lacked the statutory required language to say "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." On November 27, 2023, at 10:30 a.m., licensed	03090		

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03090	Continued From page 34 assisted living director (LALD)-C stated, "That was the initial sign I posted, but I can change it right away to have the correct wording." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *11/28/23*
Time: 14:10:00
Report: 7963231147

Food and Beverage Establishment Inspection Report

Location:
Risen Home Care Llc
5333 Bryant Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038815
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632278846
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: CHICKEN SALAD
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

MET WITH ANGELIQUE KAPILA WITH RISEN HOME CARE AND TESA BROWN, NURSE SURVEYOR WITH MDH.

DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-COLD HOLDING
-SUSCEPTIBLE POPULATION REQUIREMENTS

ESTABLISHMENT IS A RESIDENTIAL HOME DOING SAME DAY SERVICE MEAL PREPARATION.

DISHWASHER HAS A SANITIZER CYCLE WHICH REACHED THE REQUIRED SANITIZER TEMPERATURE OF 160 DEG F AFTER TESTING.

KITCHEN HAS LINOLEUM FLOORS, WOOD CABINETS LAMINATE COUNTERTOPS AND A POPCORN TEXTURED CEILING.

Type: Full
Date: *11/28/23*
Time: 14:10:00
Report: 7963231147
Risen Home Care Llc

Food and Beverage Establishment Inspection Report

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 7963231147 of 11/28/23.

Certified Food Protection Manager: Angelique Kapila

Certification Number: FM 109780 Expires: 02/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Angelique Kapila
LALD-C

Signed: Peggy Spadafore
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963231147

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

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

Date 11/28/23
Time In 14:10:00
Time Out

Risen Home Care Llc	**Address** 5333 Bryant Avenue North	**City/State** Brooklyn Center, MN	**Zip Code** 55430	**Telephone** 7632278846
License/Permit # 0038815	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 11/28/23

Inspector (Signature) Peggy Spurley