Electronically Delivered

March 11, 2022

Administrator
All Saints Senior Living
1880 Independence Drive
Shakopee, MN 55379

RE: Project Number(s) SL29576015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572 and/or Minn. Stat. Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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. § 144A.474, Subd. 11(a), fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

In accordance with Minn. Stat. § 144A.474, Subd. 11(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subd. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144A.474, Subd. 11(a)(6), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's client(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. § 144A.474, Subd. 12, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order date.

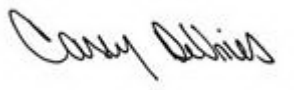
A state licensing order under Minn. Stat. § 144A.44 Subd. 1(14), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat.
§ 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
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Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29576	A. BUILDING: _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINTS SENIOR LIVING	1880 INDEPENDENCE DRIVE SHAKOPEE, MN 55379

(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 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: SL#29576015 On, February 14, 2022 through February 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 84 residents; 82 receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements	0 485		

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0 485	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all 82 residents who received services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 485		

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0 485	Continued From page 2 The findings include: On February 14, 2022, at approximately 10:35 a.m., the surveyor observed the menu for the week of February 14, 2022, through February 20, 2022, posted on a white board in the second-floor dining area. On February 14, 2022, at approximately 9:45 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated the licensee offered three meals a day served per Minnesota Food Code. On February 14, 2022, at approximately 10:55 a.m., registered nurse (RN)-E stated she was not aware of the menu posting requirement and referred the surveyor to the head cook. Head cook (HC)-H acknowledged the week in advance menu was missing but stated the next week's menu was posted on Wednesdays. The licensee's policy for menu posting was requested but was not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact	0 550		

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0 550	Continued From page 3 information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all the licensee's current 84 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: During a facility tour on February 14, 2022, at approximately 10:45 a.m., the surveyor observed the common areas shared by residents, staff, and visitors, lacked the required posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. On February 14, 2022, at approximately 11:02 a.m., licensed assisted living director (LALD)-C acknowledged the required content was not posted in the common areas. LALD-C stated they had put the information in a binder in common	0 550		

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0 550	Continued From page 4 area. The licensee's Grievance/Feedback Form Guideline and Action Plan policy, dated November 2016, lacked indication for posting information for grievance procedure that included the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 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 observation, 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 four residents (R2 and R4) with records reviewed.	0 630		

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0 630	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 15, 2022, at approximately 9:55 a.m., the surveyor observed R2 in the locked memory care unit. During medication administration, R2 was swearing and cursing and refused her medication. Unlicensed personnel (ULP)-F stated R2 was anxious due to two staff members being present. ULP-F stated they would reapproach R2 with medication later. R2's diagnoses included vascular dementia without behavior, anxiety disorder and unspecified abnormalities of gait and mobility. R2's IAPP, dated January 17, 2022, indicated R2 can follow direction, R2 is able to report abuse or neglect, R2 was not anxious or depressed, and R2did not have impaired judgment due to mental health issues. R2's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R4's diagnoses included Legally blind, gastroesophageal reflux disease (GERD), osteoporosis and panlobar emphysema. R4's service plan, dated August 21, 2021, indicated R4 received services including toileting,	0 630		

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0 630	Continued From page 6 safety checks, oxygen management, medication administration, laundry, housekeeping, grooming, denture care, dressing stand by assist, bathing, and meal socialization. R4's IAPP, dated January 21, 2022, indicated R4 was forgetiful, cannot give accurate information, not able to ambulate safely, limited range of motion, weakness, depressed, chronic condition restricting physical activity, impaired vision, and impaired earing. On February 16, 2022, at approximately 12:45 p.m., the registered nurse (RN)-A acknowledged R2 was receiving care in dementia care unit because could not make sound judgements. In addition RN-A acknowledged R4's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The licensee's policy for abuse prevention was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 810 SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 7 (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 document review, and interview, the licensee failed to provide all required content of the fire safety and evacuation plan, the minimum required frequency on training of employees and residents on the fire safety and evacuation plan, and to develop a policy to ensure the minimum number of fire safety and evacuation drills that will be performed by employees. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care.	0 810		

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0 810	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 15, 2022, at approximately 1:15 p.m., survey staff reviewed the facility's fire safety and evacuation plan documentation, training policies and procedures, and related records: FIRE SAFETY AND EVACUATION PLAN -The documentation lacked fire protection procedures necessary for residents that can self assist in a fire or similar emergency. -The plan documentation lacked procedures for employee actions to be taken in the event of a fire or similar emergency for addressing total evacuation, and relocation, including unique resident-specific situations during an evacuation. TRAINING -The facility's documented policy 9/13/2021, showed the incorrect frequency of employee training on fire safety and evacuation of new employee orientation and thereafter, at least annually. The minimum required training is upon hire and twice a year. FIRE DRILLS AND EVACUATION -The facility's documented policy 9/13/2021, showed the incorrect frequency of employee evacuation drills performed annually, rather than the required fire safety and evacuation drills to be performed by employees twice per year per shift,	0 810		

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0 810	Continued From page 9 with at least one evacuation drill every other month. -Record review showed the licensee has performed employee fire drills monthly, but lacked evacuation drills as there were no noted evacuation details on the fire drill records. Fire and evacuation drills may be performed at the same time and documented as such. On February 15, 2022, at approximately 2:30 p.m., the licensed assisted living director-C and the director of maintenance-I acknowledged the findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;	0 920		

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0 920	Continued From page 10 (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R3, and R4) with records reviewed. 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 February 14, 2022, at approximately 9:45 a.m., the licensed assisted living director (LALD)-C provided a blank Assisted Living Contract and indicated the contract was used by the licensee for all residents who received services by licensee. R1's record included a copy of the Assisted Living Contract dated August 1, 2021. R1's contract lacked a disclosure of the facility's ability to provide specialized diets and a disclosure of the category of assisted living facility license held by the facility.	0 920		

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0 920	Continued From page 11 R2's record included a copy of the Assisted Living Contract dated August 1, 2021. R2's contract lacked a disclosure of the facility's ability to provide specialized diets and a disclosure of the category of assisted living facility license held by the facility. R3's record included a copy of the Assisted Living Contract dated August 1, 2021. R3's contract lacked a disclosure of the facility's ability to provide specialized diets and a disclosure of the category of assisted living facility license held by the facility. R4's record included a copy of the Assisted Living Contract dated. August 1, 2021. R4's contract lacked a disclosure of the facility's ability to provide specialized diets and a disclosure of the category of assisted living facility license held by the facility. On February 16, 2022, at approximately 10:45 p.m., LALD-C acknowledged the contract lacked disclosure of specialized diets and disclosure of the category of assisted living facility license held by the facility. LALD-C stated they believed the Uniform Disclosure of Assisted Living Services and Amenities (UDULSA) would provide this information to residents and families. The licensee lacked a policy for Assisted Living Licensure contract requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		

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0 970	Continued From page 12	0 970		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 84 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) 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 February 14, 2022, at approximately 9:45 a.m., licensed assisted living director (LALD)-C provided a blank Assisted Living Contract and indicated the contract was used by the licensee for all residents who received services. R1's record included a copy of the Assisted Living Contract dated August 1, 2021. R1's contract	0 970		

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0 970	Continued From page 13 indicated the resident will indemnify (compensate for harm or loss) and hold harmless provider and its employees for the health and safety or personal property of a resident. R2's record included a copy of the Assisted Living Contract dated August 1, 2021. R2's contract indicated the resident will indemnify (compensate for harm or loss) and hold harmless provider and its employees for the health and safety or personal property of a resident. R3's record included a copy of the Assisted Living Contract dated August 1, 2021. R3's contract indicated the resident will indemnify (compensate for harm or loss) and hold harmless provider and its employees for the health and safety or personal property of a resident. R4's record included a copy of the Assisted Living Contract dated August 1, 2021. R4's contract indicated the resident will indemnify (compensate for harm or loss) and hold harmless provider and its employees for the health and safety or personal property of a resident. On February 14, 2022, at approximately 12:35 p.m., LALD-C acknowledged the licensee's assisted living contract included a waiver of liability for health and safety or personal property. LALD-C stated the contract would be revised. The licensee lacked a policy for Assisted Living Licensure contract requirements, effective August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the residents service plan was revised to include added service for three of three residents (R3, R6, R7) with 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) and was issued at a pattern scope (when more than a limited number	01640		

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01640	Continued From page 15 of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3's diagnoses include Alzheimer's, muscle weakness, difficulty walking. R3's service plan dated August 5, 2021, indicated R3 received services for bathing, meal assist-set up, dressing, oral cares, medication management, transfers, toileting, and safety checks. R3's Physical Device document, dated February 7, 2022, indicated R3 used a wheelchair, anti-tip/roll back, and foot pedals. On February 15, 2022, at approximately 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-B escort R3 from bedroom to dining area in a wheelchair without footrests. R3's feet contacted the floor multiple times on way to dining area. R3 complained of foot pain. This created a risk for injury. R6 R6's diagnoses include hypertension (HTN), atrial fibrillation (A-FIB), generalized weakness, dementia with out behavioral disturbance. R6's service plan dated August 5, 2021, indicated R3 received services for bathing, meal assist, dressing, oral cares, laundry, homemaking, medication administration, transfer with full mechanical lift, escort assistance, toileting, skin care.	01640		

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01640	Continued From page 16 R6's Physical Device document, dated January 24, 2022, indicated R6 used a wheelchair, electric lift chair, anti-tip/roll back, and foot pedals. On February 15, 2022, at approximately 9:21 a.m., the surveyor observed ULP-F escort R6 from dining area back to bedroom in a wheelchair without footrests. R6 held their feet off floor as ULP-F pushed the wheelchair. This created a risk for injury if R6 were to let feet fall to floor. R7 R7's diagnoses include encephalopathy, muscle weakness, and urinary tract infection. R7's service plan dated January 13, 2022, indicated R7 received services for bathing, meal assist, dressing, oral care, grooming, bed making, laundry, medication administration, transfer assist, and toileting assistance. R7's Physical Device document dated January 18, 2022, indicated R7 used a wheelchair, electric lift chair, anti-tip/roll back, and foot pedals. On February 15, 2022, at approximately 9:19 a.m., the surveyor observed ULP-G escort R7 from dining area back to bedroom in a wheelchair without footrests. R7 held their feet off floor as ULP-G pushed the wheelchair. This created a risk for injury if R7 were to let feet fall to floor. On February 15, 2022, at approximately 9:45 a.m., licensed practical nurse (LPN)-D stated staff are trained to place foot pedals on wheelchair and push wheelchair forward when transporting residents. Residents who self-propel would not require foot pedals.	01640		

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01640	Continued From page 17 On February 16, 2022, at approximately 12:25 p.m., the licensed assisted living director (LALD)-C acknowledged the licensee had not revised the resident service plans to reflect the latest reassessment. The licensee's Nursing Services policy, dated July 2014, indicated the registered nurse (RN) may delegate nursing services to a person who has successfully completed staff orientation, been trained in the services to be provided, and who has demonstrated to the RN the ability to competently follow the procedures. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	01730		

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01730	Continued From page 18 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management plan with the required content for three of four residents (R2, R3 and R4) with 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 was issued at a widespread scope (when problems are pervasive or represent a systemic	01730		

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01730	Continued From page 19 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 14, 2022, at approximately 9:45 a.m., registered nurse (RN)-A stated the licensee provided medication management services for the licensee's residents. On February 15, 2022, at approximately 9:55 a.m., the surveyor observed R2's medication administration. R2's service plan, dated August 13, 2021, indicated R2 received services including safety checks, medication administration, laundry, wellness visit, oral care reminders, dressing set up and meal assist. R2's Annual/Change in Condition Assessment, dated February 1, 2022, lacked medication management services provided by nurse and unlicensed personnel (ULP) (included PRN) and identification of medication management tasks that may be delegated to unlicensed personnel. On February 15, 2022, at approximately 7:50 a.m., the surveyor observed a ULP administer morning medications to R2 which included acetaminophen 1000 milligrams (mg), calcium carbonate 315-200 mg, fiber 4000 mg, and Lidocaine patch 4 percent (%). R3's service plan, dated August 5, 2021, indicated R3 received services including meal assist, activities of daily living, laundry, medication administration, toileting, and mobility.	01730		

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01730	Continued From page 20 R3's Annual/Change in Condition Assessment, dated February 7, 2022, lacked medication management services provided by nurse and ULP and identification of medication management tasks that may be delegated to unlicensed personnel. On February 15, 2022, at approximately 8:20 a.m., the surveyor observed a ULP administer morning medications to R3 which included levothyroxine tab 175 microgram (mcg), acetaminophen 500 milligram (mg), fluticasone furoate vilanterol, calcium +D3 tab 315-250 two tabs and losartan potassium 50 mg. R4's service plan, dated August 21, 2021, indicated R4 received services including toileting, safety checks, oxygen management, medication administration, laundry, housekeeping, grooming, denture care, dressing stand by assist, bathing, and meal socialization. R4's Annual/Change in Condition Assessment, dated January 21, 2022, lacked medication management services provided by nurse and unlicensed personnel, medication management tasks that may be delegated to ULPs, and resident/client-specific requirements for oxygen parameters and continuous positive airway pressure (CPAP). On February 16, 2022, at approximately 12:10 p.m., RN-A acknowledged the medication management plans lacked the required content. The licensee's Medication and Treatment policy, dated March 2021 and reviewed August 2021, indicated the missing content will be included in a medication management plan.	01730		

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01730	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel ((ULP)-B), demonstrated competency for specific instructions for one of one resident (R3) during medication administration. 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).	01750		

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01750	Continued From page 22 The findings include: On February 14, 2022, at approximately 7:50 a.m., ULP-B set up medication for R3by punching out of packets into a medication cup. On February 14, 2022, at approximately 7:55 a.m. ULP-B administered medication pills whole to R3. R3 chewed all medication which included a capsule. R3's service plan, dated August 5, 2021, indicated R3 received services for meal assist, activities of daily living, laundry, medication administration, toileting, and mobility. R3's provider orders, dated February 7, 2022, stated "OK to crush meds per pharmacy recommendation dx: oropharyngeal dysphagia." R3's record lacked resident specific instruction to crush specific medication on the medication administration record (MAR). On February 15, 2022, at approximately 12:15 p.m., licensed practical nurse (LPN)-D acknowledged R3's MAR lacked specific instructions on medication. LPN-D stated although R3's MAR lacked information, they did show where instruction would be shown to ULP on Point of Care (POC) during medication administration. The licensee's Medication & Treatments policy, dated August 14, 2014, indicated the staff member should compare the information on the MAR with the label on the mediation container. The policy read, "The following information should be in all places:	01750		

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01750	Continued From page 23 -Individual tenant's name -Name of medication -Strength and dosage of medication -Route -Time that the medication should be given -Any special instructions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy 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,	01790		

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01790	Continued From page 24 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 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 written procedures for the unlicensed personnel (ULP) providing	01790		

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01790	Continued From page 25 medications for residents having unplanned time away when the licensed nurse was not available; and failed to provide complete documentation of medications sent with one of one resident (R4) who had an unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's service plan dated August 21, 2021, indicated R4 received services to include medication administration. R4's medication log for narcotics indicated R4 received leave of absence medications while away from home on June 7, 2021, and June 17, 2021. R4's record lacked documentation of the medications provided to the resident or the resident's designated representative to include who received the medications, the person who provided the medications to the resident, the name and quantity of the medications provided, if any unused medications were returned, and a review by the registered nurse to verify that the procedure was followed, and the documentation completed for the above noted times away from home. On February 16, 2022, at approximately 12:20 p.m., RN-A acknowledged the required content	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29576	A. BUILDING: _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINTS SENIOR LIVING	1880 INDEPENDENCE DRIVE SHAKOPEE, MN 55379

(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 26 was missing and stated the licensee has forms for unplanned time away, though none were provided. The licensee's Medication & Treatments policy, dated March 2021, and reviewed August 2021, indicated medications for planned and unplanned time away will be documented including: - the resident must be provided written information on medications, including any specific instructions for administering or handling the medications, including controlled substances; - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; and - how the RN shall be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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	29576	A. BUILDING: _____ B. WING _____	02/16/2022

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ALL SAINTS SENIOR LIVING	1880 INDEPENDENCE DRIVE SHAKOPEE, MN 55379

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01890	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of expired medications for two of four residents (R1 and R4) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 15, 2022, at approximately 9:36 a.m., a review of the medication storage area for R1 was completed. The surveyor observed the following expired medication with registered nurse (RN)-A; oxycodone tab 5 milligram (mg) take one tab by mouth every six hours as needed, expiration date February 2, 2022. R1's service plan, dated September 3, 2021, indicated R1 received services including medication management. R1's provider orders, dated December 10, 2021, included oxycodone tab 5 milligram (mg), every six hours as needed, sertraline tab 50 mg at bedtime, metoprolol suc tab 25 mg extended release at bedtime, and furosemide tab 40 mg every other day. On February 15, 2022, at approximately 9:10 a.m., the surveyor observed R4's medication	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29576	A. BUILDING: _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINTS SENIOR LIVING	1880 INDEPENDENCE DRIVE SHAKOPEE, MN 55379

(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
01890	Continued From page 28 cabinet and polyethylene glycol powder 3350 - mix 17 mg in eight ounce of liquid as needed was beyond the manufacturer's use by date of June 15, 2021. R4's service plan, dated August 21, 2021, indicated R4 received services including medication administration. R4's provider orders, dated September 27, 2021, included polyethylene glycol powder 3350 mix 17 mg in eight ounce of liquid as needed, and tramadol hcl tab 50 mg as needed. On February 16, 2022, at approximately 12:30 p.m., registered nurse (RN)-A acknowledged both R1 and R4's medication cabinets had medications beyond the manufactures' use by date. The licensee's Medication & Treatment policy, dated March 2021, and reviewed August 2021, indicated expired medications will be disposed of according to the accepted practices of the Minnesota Board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALL SAINTS SENIOR LIVING	1880 INDEPENDENCE DRIVE SHAKOPEE, MN 55379

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01940	Continued From page 29 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R4) with oxygen and continuous positive airway pressure (CPAP). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 30 limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's service plan, dated August 21, 2021, indicated R4 was receiving oxygen and CPAP treatments. R4's provider orders, dated September 27, 2021, indicated R4 was receiving oxygen treatment. R4's treatment management plan Annual/Change in Condition Assessment, dated January 21, 2022, lacked the procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On February 16, 2022, at approximately 12:40 p.m., the registered nurse (RN)-A, acknowledged the R4's treatment management plan was lacking the above content. The licensee's Medication & Treatments policy, dated March 2021, and reviewed August 2021, indicated the missing content above should be included. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 31 has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. The hazards identified on the HVA plan must be mitigated to protect the residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On February 15, 2022, between 10:15 to 12:40 p.m., survey staff toured the facility with the Director of Maintenance-I.	02040		

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02040	Continued From page 32 On February 15, 2022, at approximately 1:10 pm, survey staff received the HVA documentation (undated "Kasier Permanente) for review, and the following findings were observed: -The HVA plan lacked specific hazard assessment content on and around the property to protect the dementia care residents from harm. Hazard assessments on the HVA plan must include specific safety risks or potential hazard vulnerabilities such as resident elopement throughout and around the memory care portion of the building including deactivation of power doors due to loss of power or fire alarm activation, active exit-seeking residents that may follow a visitor through a secured door, assessing nearby highways when elopement occurs, and the risks of the misuse of portable fire extinguishers or architectural accessories throughout the building that need to be assessed. - The HVA plan lacked mitigations documentation including safety measures and/or training provided to the safety risk assessment identified on and around the property to protect all memory care residents from harm. February 15, 2022, at approximately 2:30 p.m. during the exit interview, survey staff explained that the licensee must develop and implement the HVA plan to protect memory care residents from harm. All potential safety risks or harm on and around the property must be identified, assessed, and mitigated in the HVA plan documentation and implemented to protect memory care residents from harm. The licensed assisted living director-C acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 33 (14) days	02040		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *02/15/22*
Time: 14:55:08
Report: 7994221035

Food and Beverage Establishment Inspection Report

Location:
All Saints Senior Living
1880 Independence Drive
Shakopee, MN55379
Scott County, 70

Establishment Info:
ID #: 0038051
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522337351
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.

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

THIS WAS AN UNANNOUNCED INSPECTION. I SPOKE WITH THE PERSON IN CHARGE ABOUT THIS REPORT AND ANY ITEMS WITHIN.

TEMPERATURES:
TOMATOES 40
MILK 39

OLD CFPM RECENTLY LEFT THE FACILITY. INCLUDING CFPM INFO IN THE EMAIL.

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 7994221035 of 02/15/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994221035

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	0	**Date**	02/15/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	14:55:08
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
All Saints Senior Living	1880 Independence Drive	Shakopee, MN	55379	9522337351

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0038051		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		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:** 02/16/22

Inspector (Signature) Crystal Elva