November 7, 2023

Licensee
Faribault Senior Living
843 Faribault Road
Faribault, MN 55021

RE: Project Number(s) SL30786015

Dear Licensee:

On October 25, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 26, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Interim Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

PMB

Electronically Delivered

August 1, 2023

Licensee
Faribault Senior Living
843 Faribault Road
Faribault, MN 55021

RE: Project Number(s) SL30786015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30786	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT SENIOR LIVING	843 FARIBAULT ROAD FARIBAULT, MN 55021

(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: SL30786015-0 On July 24, 2023, through July 26, 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 94 active residents; 55 receiving services under the Assisted Living with Dementia Care 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for one of two unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on April 2, 2019. ULP-A's Nursing Assistant Clinical Skills Checklist and Competency Evaluation dated April 3, 2019, indicated ULP-A was trained and competent in the hand washing skill provided by licensee. On July 25, 2023, during continuous observations from 6:00 a.m. through 7:10 a.m., ULP-A accessed medications for multiple residents from	0 510		

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0 510	Continued From page 3 the medication cart and failed to perform hand hygiene prior to each unique resident's medication administration. Additionally, ULP-A donned (put on) and doffed (took off) gloves without hand hygiene prior to donning and immediately after doffing gloves. On July 25, 2023, at 6:34 a.m., ULP-A entered R2's private room located in licensee's secured unit to provide medication administration and activities of daily living (ADLs) to R2. ULP-A provided R2's medication and then proceeded to don gloves but failed to perform hand hygiene. ULP-A obtained wet washcloths from R2's bathroom and proceeded to provide R2 cleaning with the washcloths. Once completed, ULP-A doffed their gloves and failed to perform hand hygiene. ULP-A donned new gloves with hand hygiene to continue to provide light housekeeping and ADLs to R2. ULP-A doffed gloves without hand hygiene and escorted R2 out of their private room to the common dining area. On July 25, 2023, at 12:00 p.m., clinical nurse supervisor (CNS)-D stated ULP-A should have completed hand hygiene prior to donning and immediately after doffing gloves. CNS-D stated ULP-A had approached them and stated they realized they forgot to complete hand hygiene between setting up medications for multiple sequential residents and forgot to complete hand hygiene with donning and doffing gloves. CNS-D stated all staff are trained to complete hand hygiene per policy. The licensee's 8.07 Gloves policy dated August 1, 2021, indicated hand hygiene would be completed prior to donning and after doffing gloves. No further information provided.	0 510		

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0 510	Continued From page 4 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 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 the residents).	0 580		

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0 580	Continued From page 5 The findings include: On July 24, 2023, at approximately 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated the licensee had not created or implemented a QMP. LALD-C stated the licensee was aware of the requirement to create and maintain a QMP, but one had not been created. LALD-C stated no meeting minutes or tracking would be provided since a QMP was not in place. The licensee's 2.31 Quality Management Project dated August 1, 2021, indicated a QMP program would be created, implemented, and tracked with documentation retained for at least two (2) years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 6 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 observation, interview, and record review, the licensee failed to publicly post a written emergency preparedness plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 July 24, 2023, at approximately 10:50 a.m., during a facility tour, an emergency disaster plan was not noted to be posted prominently as required. Licensed assisted living director (LALD)-C stated an emergency plan was being created but was not posted prominently. Additionally, LALD-C stated licensee had the policies and procedures related to the required,	0 680		

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0 680	Continued From page 7 "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance," as required per Minnesota Administrative Rule 4659.0100 emergency disaster and preparedness plan; but licensee had not completed the information and was currently blank. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would create and implement an emergency plan with all the required content related to an emergency plan and Appendix Z. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to	0 800		

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0 800	Continued From page 8 the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On July 25, 2023, between 11:30 a.m. and 1:50 p.m., survey staff toured the facility with maintenance (M)-E. During the facility tour, survey staff observed the following: 1. The inspection tag on the backflow prevention device was dated 2011 in the basement garbage room. Backflow prevention devices must be tested upon initial installation and at least annually thereafter. 2. Three emergency lights did not work when tested near resident rooms 125, 220, and 225. M-E explained during the facility tour that these lights required new batteries. 3. The door used to re-enter the facility from the exterior patio would not open as designed using a key fob. M-E explained during the tour that he thought there was a problem with the motor that was incorporated into the door opener key fob system. 4. In the beauty salon, a refrigerator, microwave, and stand-up hair dryer were plugged into power strips instead of being properly plugged directly into electrical outlets. Additionally, two power strips were plugged into extension cords, creating	0 800		

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0 800	Continued From page 9 a potential fire hazard. 5. The electrical panel was obstructed in the electrical room adjacent to the dining room. 6. The door closer was missing from the fire door for the clinical nurse supervisor's office. 7. A hole was observed in the fire door for the employee bathroom in the dementia care unit. 8. The lock for the electrical panel in resident room 102 in the dementia care unit was not working properly. M-E was unable to lock the panel during the tour and explained that he thought part of the lock was missing. 9. In resident room 100, several window blinds were in disrepair, making them difficult to operate. 10. The trash chute access door was not closing properly in the garbage room on the second story. M-E confirmed that the door closer was broken. These deficient conditions were verified by M-E accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 10 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, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to complete required employee evacuation drills. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 11 or has the potential to affect a large portion or all of the residents). Findings include: On July 25, 2023, between 11:30 a.m. and 1:50 p.m., survey staff toured the facility with maintenance (M)-E. During the facility tour, survey staff observed that the evacuation maps posted did not identify the location and number of resident sleeping rooms. This deficient condition was verified by M-E accompanying on the facility tour. An interview and record review were conducted on July 25, 2023, between approximately 1:50 p.m. and 2:20 p.m. with the Licensed Assisted Living Director (LALD)-C on the fire safety and evacuation plans, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee had not included the identification of unique or unusual resident needs for movement or evacuation in the fire safety and evacuation plans. The licensee failed to provide records to support that employee training on the facility fire safety and evacuation plans was completed upon hiring and at least twice per year thereafter as required by statute. The licensee failed to provide records to support that annual resident training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation had been completed as required by statute. The licensee failed to provide records to support	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 that evacuation drills had been completed twice per year per shift with at least one evacuation drill every other month as required by statute. Documented evacuation drill records were dated 08/20/2022, 09/20/2022, 1/10/2023, 03/02/2023, and 05/17/2023. These deficient conditions were verified by the licensed assisted living director (LALD)-C on July 25, 2023, at approximately 2:45 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly	0 820		

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	30786	A. BUILDING: _____ B. WING _____	07/26/2023

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0 820	Continued From page 13 affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On July 25, 2023, between 11:30 a.m. and 1:50 p.m., survey staff toured the facility with maintenance (M)-E. During the facility tour, survey staff observed a marked exit door in the dementia care unit led to an outdoor space enclosed by a fence. A gate was not installed for this fence and an exterior exit path to the public right of way was not provided. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. These deficient conditions were verified by M-E accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
0 970 SS=C	144G.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	0 970		

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0 970	Continued From page 14 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 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: On July 24, 2023, at approximately 11:00 a.m., licensed assisted living director (LALD)-C provided licensee's blank example of a Rental Lease and identified the document as licensee's assisted living contract. LALD-C stated the contract is used for all residents who reside in the facility. The assisted living contract dated August 5, 2021, read on page four (4) of fifteen (15), "29. DAMAGE OR INJURY TO RESIDENT OR HIS/HER PROPERTY: MANAGEMENT is not responsible for any damage or injury that is done to RESIDENT or his/her property.. that was not caused by MANAGEMNT."	0 970		

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0 970	Continued From page 15 On July 25, 2023, at 10:10 a.m., LALD-C stated the licensee would contact the vendor who created the assisted living contract for the licensee to have the language changed to remove the waiver of liability as indicated above. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was associated with the licensee's current assisted living facility with dementia care health facility identification number (HFID) for one of two unlicensed personnel ((ULP)-B).	01290		

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01290	Continued From page 16 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on April 2, 2019. ULP-A's Background Study Notice dated March 19, 2019, indicated ULP-A was associated with HFID 27967. HFID 27967 is related to a 144A comprehensive home care license the licensee maintained as active. On July 24, 2023, at approximately 2:00 p.m., licensed assisted living director (LALD)-C stated the licensee does not use the comprehensive license 27967. LALD-C stated the license was renewed by mistake and all assisted living services were provided under the active assisted living facility with dementia care HFID 30786. LALD-C stated the licensee was not sure if they needed to close the previous comprehensive license and kept renewing the licensee but have not served any clients under the comprehensive license since they obtained the assisted living license on August 1, 2021. LALD-C stated the licensee had not reassociated all employees in the Department of Human Services' NetStudy 2.0 background study software for the current 30786 license. LALD-C stated the licensee was in the process of moving employees from the 27967 license to the 30786 license but had failed to	01290		

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01290	Continued From page 17 complete all the transfers. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated licensee would complete a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors at the facility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure agency (also known as temporary or contracted) staff met the same training requirements as licensee personnel for one of one agency 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 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).	01350		

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01350	Continued From page 18 The findings include: ULP-B had an active four (4) week contract with a start date of July 3, 2023, through July 30, 2023. ULP-B had been working for the licensee on 4-week contracts since August 1, 2022. ULP-B's record lacked the following required orientation: -Overview of assisted living statutes; -Review of provider's policies and procedures; -Assisted living bill of rights; -Handing of resident complaints, reporting of complaints, where to report; -Review of types of assisted living services the employee will provide and provider's scope of license; and -Principles of person-centered planning/service delivery. On July 24, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-D stated the licensee as not aware agency staff were required to have a completed employee record with the same requirements as employees who were hired by the licensee. CNS-D stated the licensee only had records provided by the agency but did not provide the above identified orientation to any agency staff who have worked for the licensee. The licensee's 4.07 Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary staff would be treated and would have the same requirements as hired employees. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		

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01640 SS=D	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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and the resident or resident's designated representative to document agreement on the services to be provided for one of three residents (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, but was not likely to	01640		

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01640	Continued From page 20 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: R3 was admitted to licensee's care on April 15, 2020. R3's Service Plan Agreement dated July 7, 2022, was identified by clinical nurse supervisor (CNS)-D as R3's most current authenticated service plan. R3's Service Plan Agreement with effective date of July 25, 2023, indicated a decrease in fees from the most recent authenticated service plan, but lacked authentication by the licensee and the resident or resident's designated representative. On July 25, 2023, at 11:30 a.m., CNS-D stated R3's service plan was outdated as licensee had a change in fees and licensee had attempted to obtain authentication on all service plans. CNS-D stated R3's may have been misplaced and no current service plan with authentication would be in R3's record. The licensee's 6.06 Service Plan policy dated August 1, 2021, indicated all services plans and revisions would be authenticated by the licensee and resident or resident's designed representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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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 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	01730		

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01730	Continued From page 22 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 interview and record review, the licensee failed to develop an individualized medication management record with the required content for three of three residents (R2, R3, R4). 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: R2 R2 was admitted to licensee's care on May 29, 2021. R2's Service Plan Agreement dated May 31, 2023, indicated R2 received the service of Medication Assist effective May 27, 2021. R2's Medication Sheet dated July 2023, indicated R2 received medications administered by unlicensed personnel (ULP) for the month of July. R3 R3 was admitted to licensee's care on April 15, 2020. R3's Service Plan Agreement dated January 1,	01730		

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01730	Continued From page 23 2023, indicated R3 received the service of Medication Assist effective April 22, 2020. R3's Medication Sheet dated July 2023, indicated R3 received medications administered by unlicensed personnel (ULP) for the month of July. R4 R4 was admitted to licensee's care on January 8, 2021. R4's Service Plan Agreement dated July 1, 2022, indicated R4 received the service of Medication Assist effective January 22, 2021. R4's Medication Sheet dated July 2023, indicated R4 received medications administered by unlicensed personnel (ULP) for the month of July. R2, R3, and R4's medication management records all lacked the following required content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; adn - identification of medication management tasks that may be delegated to unlicensed personnel. On July 25, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-D stated licensee was not aware of all the required content of the medication management record. CNS-D stated licensee developed each resident's medication management record based on the licensee's electronic health record forms. CNS-D stated all	01730		

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01730	Continued From page 24 resident's medication management records would lack the identified required content. The licensee's 7.02 Mediation Management Individualized Plan policy dated August 1, 2021, indicated all required content for the medication management record which included the lacking identified content. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that 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 record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors for the facility. This deficient practice had the ability to affect all staff, residents, and visitors.	02040		

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02040	Continued From page 25 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on July 25, 2023, between approximately 1:50 p.m. and 2:20 p.m. with the Licensed Assisted Living Director (LALD)-C. Record review of the available documentation indicated that the licensee had included a hazard and vulnerability assessment tool as part of the emergency preparedness plan. An assessment of the physical environment that identified safety risks or hazards on and around the property with mitigation factors had not been completed. This deficient condition was verified by the licensed assisted living director (LALD)-C on July 25, 2023, at approximately 2:45 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:	02110		

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FARIBAULT SENIOR LIVING	843 FARIBAULT ROAD FARIBAULT, MN 55021

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02110	Continued From page 26 (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia care required policies and procedures were provided to four of four residents (R2, R3, R4, R5) at the time of move in.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30786	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT SENIOR LIVING	843 FARIBAULT ROAD FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 27 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 July 24, 2023, at 10:50 a.m. licensed assisted living director (LALD)-C provided a blank Rental Lease and identified the document as licensee's assisted living contract and all documents provided to residents at the time of move in. The contract lacked evidence residents would have received or acknowledged receiving the ten (10) required policies and procedures to be provided at the time of move in. On July 24, 2023, at 2:00 p.m., LALD-C stated the required policies and procedures were not provided to any resident at the time of move in. LALD-C stated licensee was not aware of the requirement to provide the policies and procedures to the residents, but had created the policies and procedures as required. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy dated August 1, 2021, indicated the policies would be provided to each resident at the time of move in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30786	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 28	02170		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30786	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT SENIOR LIVING	843 FARIBAULT ROAD FARIBAULT, MN 55021

(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
02170	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an evaluation for activities with all the required content for one of one resident (R2) with a dementia diagnosis. 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: R2 was admitted to licensee's care on May 29, 2021, with diagnoses that included unspecified dementia with behavioral disturbance. R2's Activities Survey dated July 24, 2023, was identified by licensed assisted living director (LALD)-C as licensee's activity evaluation document. LALD-C stated the document was used for all residents who required an activities evaluation. R2's activity evaluation document lacked the following required content: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. On July 25, 2023, at 12:00 p.m., LALD-C stated	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30786	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT SENIOR LIVING	843 FARIBAULT ROAD FARIBAULT, MN 55021

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02170	Continued From page 30 licensee was aware the activities evaluation lacked all the required content. LALD-C stated licensee had created an activities calendar for all residents based on the resident's Activities Survey, but the evaluation lacked the required content. The licensee's 3.05 ALDC Life Enrichment Programs, Activities & Outdoor Space policy dated August 1, 2021, indicated each resident would be evaluated for activities with all above identified lacking content. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

DEPARTMENT OF HEALTH

Type: Full
Date: *07/24/23*
Time: 11:00:00
Report: 1033231116

Food and Beverage Establishment Inspection Report

Location:
Faribault Senior Living
843 Faribault Road
Faribault, MN55021
Rice County, 66

Establishment Info:
ID #: 0025602
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Home Care Senior Services, Inc

Phone #: 5073316510
ID #: 33364

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Facility does not have a small diameter food probe.

Comply By: 08/07/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

Facility does not have a test kit to measure quaternary ammonium concentration.

Comply By: 08/07/23

Surface and Equipment Sanitizers

Quaternary Ammonium: = 200PPM at Degrees Fahrenheit
Location: Red Bucket
Violation Issued: No

Hot Water: = at 188 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *07/24/23*
Time: 11:00:00
Report: 1033231116
Faribault Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: Hamburger-Steam Table
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Walk In Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Baked Potato-Walk In Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Line Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Line Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Dinning Room Cooler
Violation Issued: No

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1033231116 of 07/24/23.

Certified Food Protection Manager: Jennifer L Valentyn

Certification Number: FM43859 Expires: 04/27/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jennifer L Valentyn

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033231116

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

Date 07/24/23
Time In 11:00:00
Time Out

Faribault Senior Living	Address: 843 Faribault Road	City/State: Faribault, MN	Zip Code: 55021	Telephone: 5073316510
License/Permit #: 0025602	Permit Holder: Home Care Senior Services, Inc	Purpose of Inspection: Full	Est Type:	Risk Category: M

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	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		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:** 07/24/23

Inspector (Signature)