Electronically Delivered

May 31, 2024

Licensee
Cornerstone Residence of Bagley
30 Sunset Avenue Southwest
Bagley, MN 56621

RE: Project Number(s) SL30725015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30725	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE OF BAGLEY	30 SUNSET AVENUE SW BAGLEY, MN 56621

(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: SL30725015-0 On April 29, 2024, through May 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 35 residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee record included documentation of training and competency for one of one unlicensed personnel (ULP-C) providing direct care services. This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 2 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on October 26, 2023, to provide direct care services to residents of the assisted living facility. On April 29, 2024, at 12:49 p.m., surveyor observed ULP-C administer resident (R1)'s five units of insulin using Novolog Flexpen. ULP-C stated she was trained by a registered nurse (RN) on hire as part of a training class. ULP-C's employee record included competency for subcutaneous injections by an RN but lacked specific training procedures on insulin pens. On May 1, 2024, at 10:20 a.m., RN-G stated insulin pen procedure was included in the subcutaneous injection competency, she will ensure the competency forms are updated for proper documentation of the insulin pen training for all staff. The licensee's 4.04 Employee Records policy dated August 1, 2021, indicated employee records for each person will include, records of training and in-service education required and /or provided including record of competency testing as required. The licensee's 7.36 Insulin and Subcutaneous	0 650		

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0 650	Continued From page 3 Injections policy revised on March 31, 2023, indicated only properly trained staff of [facility] may provide medication assistance or administration. ULP must be trained, and competency tested by RN, with documentation on file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal	01690		

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01690	Continued From page 4 and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accountability of controlled substances was maintained by failure to implement the policy for four of four residents (R1, R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: COMBINED NARCOTIC LOG R1's medication record contained an error related to the dose count for Robitussin AC (with codeine). R1's service plan dated January 1, 2024, indicated R1 received medication management services. R1's prescriber orders dated December 7, 2023, included Robitussin with codeine, 5 (milliliters) ml	01690		

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01690	Continued From page 5 four times a day for seven days. R1's prescriber orders dated December 19, 2023, included Robitussin AC, 10 ml every 4 hours. R1's prescriber clarification dated December 20, 2023, included Robitussin AC, 5 ml every 4 hours. On April 29, 2024, at 11:30 a.m., surveyor observed in the nurse locked narcotic drawer two bottles of codeine/guaifenesin 10 mg (milligrams)-100 mg/5 ml solution. The bottle prescription labels read: -[R1 name], prescription number 1214697 codeine/guaifenesin 10 mg-100 mg/5 ml solution. Take 10 ml by mouth every 4 hours as needed for cough; and -[R1 name], prescription number 12086268 codeine/guaifenesin 10 mg-100 mg/5 ml solution. Take 5 ml by mouth every 4 hours as needed for cough. On April 29, at 12:05 p.m., the surveyor observed the narcotic log record entry dated December 26, 2023, at 3:30 p.m., by two unlicensed personnel (ULP) no longer employed by licensee indicating 2 bottles had been combined on one narcotic log record with combined amount left of 330 ml. Clinical nurse supervisor (CNS)-B stated ULPs were not taught that way, a nurse should have been contacted, and if prescription numbers were different, each needed individual count sheets. On April 29, at 12:07 p.m., surveyor reviewed R1's narcotic log record with CNS-B and licensed practical nurse (LPN)-E. LPN-E stated she had signed the narcotic count with an ULP on December 26, 2023, at 3:50 p.m. when the medication was administered by the ULP. LPN-E stated she didn't think of writing a medication	01690		

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01690	Continued From page 6 error for combining the two narcotic log counts. LACK OF NARCOTIC LOG RECORD COUNTS R1, R4, R5, R6 's narcotic log records lacked daily counts as per licensee policy. On April 29, 2024, at 11:15 a.m., LPN-E and registered nurse (RN)-D stated together they count the nurses narcotic drawer once a week, when medications are set-up. Additionally, they stated if one of them is gone, a ULP will count with a nurse. On April 29, 2024, at 11:30 a.m., surveyor and RN-D observed in the nurse locked narcotic drawer four bottles of liquid medications. RN-D unable to locate the Narcotic Log Record in the Narcotic Log Record book for the following medications: -[R1 name], codeine/guaifenesin 10 mg-100 mg/5 ml solution. Take 10 ml by mouth every 4 hours as needed for cough, 225 ml remaining in bottle; -[R1 name], codeine/guaifenesin 10 mg-100 mg/5 ml solution. Take 5 ml by mouth every 4 hours as needed for cough, 75 ml remaining in the bottle; -[R4 name], codeine/guaifenesin 10 mg-100 mg/5 ml solution. Take 5 ml by mouth four times a day as needed for cough up to 10 days, 195 ml remaining in the bottle; and -[R5 name], morphine 100 mg/5 ml solution. Place 2 ml in the cheek every one hour as needed. Call to initiate, bottle unopened, seal was intact. On April 29, 2024, at 11:35 a.m., LPN-E stated they no longer count the cough medicines as they are not used anymore and have never counted the morphine as it was never opened. On April 29, 2024, at 11:40 a.m., CNS-B stated	01690		

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01690	Continued From page 7 R5 was on hospice, but then got better so went off hospice, the morphine has been discontinued, it should have been logged and destructed. Additionally, CNS-B stated all narcotics should be counted as per policy. On April 29, 2024, at 11:45 a.m., the following Narcotic Log Records were found filed in the following resident's paper medical record: -[R1 name], Medication: guaifenesin AC (with codeine), Strength: 10 mg/100 mg, Route: by mouth, prescription number: 1214697. Last documented count entry was dated December 26, 2023, at 7:00 a.m., Amount left: 225 ml. (combined with below bottle) -[R1 name], Medication: guaifenesin AC, Strength: 10 mg/100 mg, Route: by mouth, prescription number: (not entered). Last documented count entry was dated December 28, 2023, at 3:30 p.m., Amount left: 300 ml. -[R4 name], Medication: guaifenesin AC, Strength: 10 mg-100 mg/5 ml, prescription number: 1215276. Last documented count entry was dated January 10, 2024, at 8:00 a.m., Amount left: 195 ml. -[R6 name], no narcotic log was found for morphine 100 mg/5 ml solution. On April 29, 2024, at 12:22 p.m., surveyor observed with nursing staff, the nurse narcotic drawer the following medication for R6: lorazepam 0.5 mg, take ½ (0.25 mg) tablet by mouth at 2 p.m. Last documented count entry was dated April 25, 2024, at 5:00 p.m., by LPN-E indicated 60 tablets was received by pharmacy, and amount left was 63. LPN-E stated the nurse drawer would be counted this week with RN-D. The licensee's 7.26 Narcotic Log policy dated August 1, 2021, indicated staff at [facility] who	01690		

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01690	Continued From page 8 administer schedule II-controlled substances will participate in recording schedule II medications on an individual page in the narcotic book. All schedule II-controlled substances will be counted and recorded on the narcotic count record and compared with the quantities listed on the narcotic log record. This will occur at the start of every shift. This count will only be recorded in the narcotic count sheet and not on the medication administration record (MAR). When receiving a new supply of schedule II-controlled substances, record on an individual page in the Narcotic Log Record and count the document the narcotic (s) on a narcotic record sheet. The accuracy of the count will be documented by the initials of the personnel on the narcotic count sheet, along with the date and time count is performed. The RN supervisor will verify the documentation in the Narcotic Log Record including counts and record regularly. Discontinued controlled substances will be flagged in such a way as to prevent further use. These discontinued medications will continue to be counted with the regular narcotic inventory until they can be destroyed according to established procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 9 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the following: documentation of medication administration site by one of one unlicensed personnel (ULP-C) and maintaining correct transcription of medication information for one of four residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: MEDICATION ADMINISTRATION DOCUMENTATION ERROR R1 R1's diagnoses included diabetes, major depressive disorder, and hypertension (high blood pressure). R1's service plan dated January 1, 2024, indicated R1 received medication management	01760		

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01760	Continued From page 10 services. R1's prescriber orders dated September 26, 2023, included Novolog Flexpen 100 units/milliliter (ml), five milligrams (mg), give five units after each meal. Prime pen with 2 units and waste. Indicated for diabetes mellitus II. On April 29, 2024, at 12:49 p.m., surveyor observed ULP-C administer five units of Novolog Flexpen to upper left side of R1's abdomen. After administration of insulin, R1 documented the Novolog 5 units in the electronic medication administration record (EMAR). ULP-C did not document site where insulin was given. ULP-C stated there was nowhere on the EMAR to document the site. On April 29, 2024, at 3:00 p.m., clinical nurse supervisor (CNS)-B stated ULP-C should be documenting insulin administration site and was not aware it was not on the EMAR. Licensed practical nurse (LPN)-E stated she did not know how to add injection location to the EMAR. The licensee's 7.36 Insulin and Subcutaneous Injections policy reviewed on March 31, 2023, indicated to document insulin injection and site on the residents EMAR. TRANSCRIPTION ERROR R6 R6's diagnoses included generalized anxiety disorder, major depressive disorder, and dementia. R6's Service Plan dated December 8, 2023, indicated R2 received medication management services.	01760		

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01760	Continued From page 11 R6's prescriber order dated March 18, 2023, included lorazepam 0.25 mg at 2 p.m. daily. On April 29, 2024, at 11:00 a.m., surveyor observed two locked narcotic drawers, inside a locked medication room. One locked narcotic drawer was counted by ULPs, and the other locked medication drawer was assessable only to nurses and counted by the nurses. The nurse drawer contained the following medication for R6: lorazepam 0.5 mg, take ½ (0.25 mg) tablet by mouth at 2 p.m. The surveyor observed two blister packs, one with 30 (1/2 tablets), and one with 3 (1/2 tablets), confirmed by registered nurse (RN)-D. Narcotic count sheet dated April 25, 2024, at 5:00 p.m., completed by LPN-E indicated 60 tablets were received by pharmacy, and amount left was 63. RN-D and LPN-E investigated and found the pharmacy packing slip dated April 25, 2024, indicating the following medications was received for R6: lorazepam 0.5 mg tablet, quantity 15. LPN-E stated she must have transcribed the wrong number on the narcotic count sheet, should have been 15 tablets (30 ½ tabs) received. LPN-E stated R6 received another medication at the same time and that quantity was 60, so must have just put the wrong number down. RN-D and LPN-E stated the nurse controlled med drawer was only counted once a week. The licensee's 7.24 Medication Error policy revised on April 21, 2022, indicated anytime a medication error occurs, the RN must complete re-education with the staff that completed the error and document in the employee file. The licensee's 7.26 Narcotic Log policy dated August 1, 2021, indicated staff at [facility] who administer schedule II-controlled substances will	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30725	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE OF BAGLEY	30 SUNSET AVENUE SW BAGLEY, MN 56621

(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
01760	Continued From page 12 participate in recording schedule II medications on an individual page in the narcotic book. When receiving a new supply of schedule II-controlled substances, record on an individual page in the Narcotic Log Record and count the document the narcotic (s) on a narcotic record sheet. The accuracy of the count will be documented by the initials of the personnel on the narcotic count sheet, along with the date and time count is performed. The RN supervisor will verify the documentation in the Narcotic Log Record including counts and record regularly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health
Food, Pools and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/29/24*
Time: 11:00:51
Report: 1002241054

Food and Beverage Establishment Inspection Report

Location:

Cornerstone Residence Bagley
30 Sunset Avenue Sw
Bagley, MN56621
Clearwater County, 15

Establishment Info:

ID #: 0037507
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2186942701
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.

Surface and Equipment Sanitizers

Utensil Surface Temp: = at 160 Degrees Fahrenheit
Location: THERMOLABEL - DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 167 Degrees Fahrenheit - Location: SPAGHETTI SAUCE - WARMER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: CHICKEN SALAD - MAXIMUM COOLER
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: AMBIENT TEMP - TURBO AIR FREEZERS (2)
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: AMBIENT TEMP - TURBO AIR COOLER
Violation Issued: No

Type: Full
Date: *04/29/24*
Time: 11:00:51
Report: 1002241054
Cornerstone Residence Bagley

Food and Beverage Establishment Inspection Report

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

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 1002241054 of 04/29/24.

Certified Food Protection Manager Doris K. Kaiser

Certification Number: FM96837 Expires: 01/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Junelle Kaiser
Housing Director

Signed: _____

Cassandra Hua
Public Health Sanitarian III
218-308-2142
Cassandra.Hua@state.mn.us

Report #: 1002241054

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975

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

Date 04/29/24
Time In 11:00:51
Time Out

Cornerstone Residence Bagley	Address: 30 Sunset Avenue Sw	City/State: Bagley, MN	Zip Code: 56621	Telephone: 2186942701
License/Permit #: 0037507	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

Compliance Status						COS	R
Surpervision							
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:** 05/01/24

Inspector (Signature)