DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 17, 2023

Licensee
New Life Health Service
4756 Decatur Avenue North
New Hope, MN 55428

RE: Project Number(s) SL35815015

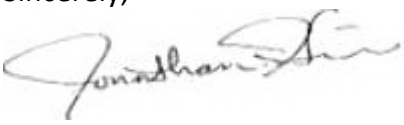
Dear Licensee:

On March 24, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 5, 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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

Electronically Delivered

February 9, 2023

Licensee
New Life Health Service
4756 Decatur Avenue North
New Hope, MN 55428

RE: Project Number(s) SL35815015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 5, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	4756 DECATUR AVENUE NORTH NEW HOPE, MN 55428

(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: SL35815015-0 On January 4, 2023, through January 6, 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 five (5) residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers with Dementia Care. 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.	
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain current job description, including qualifications, responsibilities, and identification of staff persons providing supervision for one of one unlicensed personnel (ULP-B) and failed to ensure an annual performance evaluation was completed for one of	0 650		

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0 650	Continued From page 2 one registered nurse (RN)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired June 09, 2022, and provided direct cares for the residents of the facility. On January 05, 2022, at 8:30 a.m., ULP-B was observed administering medications to R1. ULP-B's record lacked an employee record with the required contents to include: -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. RN-D RN-D's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. RN-D had a hire date of March 10, 2020, to provide direct care services to the licensee's residents. On January 05, 2023 at 11:20 a.m., housing	0 650		

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0 650	Continued From page 3 manager (HM)-C verified RN-D's record lacked evidence of an annual performance review. Also, HM-C confirmed ULP-B's record lacked current job description with required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment,	0 660		

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0 660	Continued From page 4 documentation of a completed health history and symptom screening for one of three employees (registered nurse (RN)-D). 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: RN-D had a start date of March 10, 2020. RN-D's employee record did not contain the following: - documentation of a completed TB health history and symptom screening. On January 06, 2022, at 11:30 a.m., Housing manager (HM)-C confirmed RN-D's record lacked evidence of a completed TB health history and symptom screening, and was unsure why it was not completed. The licensee's Tuberculosis Screening/Prevention policy, dated August 1, 2021, indicated "Baseline TB Testing: Baseline TB screening at the time or hire is required for an HCWs in Minnesota. Baseline TB screening consists of three components: (1)assessing for current symptoms of active TB disease, and (2) assessing TB history and 3) TB testing for the presence or infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test."	0 660		

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0 660	Continued From page 5 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 6 (5) have a written policy and procedure regarding missing tenant 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 have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on January 04, 2023, at 10:30 a.m., the surveyor did not observe a posting of the licensee's EPP. The licensee lacked evidence of the following required content:	0 680		

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0 680	Continued From page 7 - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; and - subsistence needs for staff and residents during emergency situation. On January 5, 2023, at 12:00 p.m. housing manager (HM)-C stated he was familiar with Appendix Z which is part of the EPP. HM-C verified the EPP lacked required content. The licensee's 7.01 Disaster Planning and Emergency Preparedness Plan policy dated April 23, 2021, indicated the EPP would include the above information but did not specify it should be located in a conspicuous area. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide	0 770		

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0 770	Continued From page 8 sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide all-weather walks within the lot lines to the primary entrance. 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 January 5, 2023, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed an all-weather walk covered with snow that was not being maintained outside the patio door. This patio door was identified as an exit on the evacuation plans posted in the facility. This deficient condition was verified by HM-C accompanying on the facility tour.	0 770		

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0 770	Continued From page 9 TIME PERIOD FOR CORRECTION: Two (2) days	0 770		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Surveyor: Hassan, Safia M. Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected throughout the facility. This deficient condition had the potential to affect all	0 780		

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0 780	Continued From page 10 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, 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). Findings include: On January 5, 2023, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed that the smoke alarm in the basement installed outside the sleeping rooms was not interconnected so that actuation of one alarm caused all alarms in the dwelling unit to operate. This deficient condition was verified by HM-C accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790		

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(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
0 790	Continued From page 11 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the ability 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, 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). Findings include: On January 5, 2023, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed that portable fire extinguishers were not provided with tags or labels from certified service personnel indicating that annual maintenance had been performed. These deficient conditions were visually verified by HM-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	01/05/2023

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NEW LIFE HEALTH SERVICE	4756 DECATUR AVENUE NORTH NEW HOPE, MN 55428

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0 800	Continued From page 12	0 800		
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 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 January 5, 2023, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed the following: 1. An egress window was obstructed by a cover that was bolted down and covered with snow. 2. The smoke alarm installed outside the sleeping	0 800		

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0 800	Continued From page 13 rooms on the main floor did not work when tested by HM-C. 3. A smoke alarm in a resident sleeping room on the main floor did not work when tested by HM-C. 4. Burnt used cigarettes were observed being disposed of below the ramp at the front door instead of in a proper disposal container. 5. The electrical panel was obstructed by a dresser and also by additional items being stored in this location. 6. The laundry room door was damaged. 7. The light fixture cover was missing in a resident room on the main floor. 8. Five light bulbs were not working in the main floor bathroom. These deficient conditions were verified by HM-C accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) 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 emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 14 (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: Surveyor: Hassan, Safia M. Based on record review and interview, the licensee failed to develop fire safety and evacuation plans with the required elements; failed to provide training on fire safety and evacuation to residents capable of self-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 or has the potential to affect a large portion or all	0 810		

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0 810	Continued From page 15 of the residents). Findings include: On January 5, 2023, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed that one of the evacuation maps posted on the main floor of the facility did not identify resident room 5. On January 5, 2023, at approximately 12:30 p.m., records were provided for review. Records were reviewed by survey staff on January 5, 2023, between 12:30 p.m. and 1:30 p.m. Record review of available documentation indicated that the licensee had not developed and maintained fire safety and evacuation plans for this facility location. 1. The licensee had not identified the location and number of all resident sleeping rooms in the plans. Resident room 5 was not identified in the written plans for fire safety and evacuation provided in the New Life Health Service binder. 2. The licensee had not developed plans with employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location. The plans indicated to use the RACE acronym but were very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Limited instructions directed employees to assist residents to stoop or crawl and to confine/extinguish the fire. 3. The licensee did not include fire protection procedures necessary for residents or specific	0 810		

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0 810	Continued From page 16 procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation in the plans from this facility location. The plans direct the use of MegaMover to transport non-ambulatory clients, assist clients in the use of egress windows, and get everyone away from the house. Specific fire protection procedures necessary for residents were not included. On January 5, 2023, at approximately 1:40 p.m., the director of nursing who was also the licensed assisted living director (DON/LALD)-A verified that the fire safety and evacuation plans for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. Documentation was requested by survey staff but not provided to support that annual resident training had been completed. On January 5, 2023, at approximately 1:40 p.m., during an interview, the DON/LALD-A explained that residents participated in the facility fire drills. The DON/LALD-A verified that documentation was not available to support that annual resident training on the proper actions to take in the event of a fire had been completed and verified this deficient condition. Record review of documented fire drills indicated that evacuation drills for employees had been conducted in January, August, and December of 2022. The evacuation drill frequency requirement	0 810		

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0 810	Continued From page 17 of twice per year per shift with at least one evacuation drill every other month was not met. On January 5, 2023, at approximately 1:40 p.m., during an interview, the DON/LALD-A verified that there were no further documented evacuation drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	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 affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 820		

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0 820	Continued From page 18 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On January 5, 2023, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed two resident sleeping rooms on the main floor did not have windows that met the minimum size requirements for egress escape. Both resident sleeping rooms were occupied by residents. The clear openable area of the opened windows measured less than 20 inches in height and did not meet the minimum required opening for existing sleeping rooms of 648 square inches. This deficient condition was verified by HM-C accompanying on the facility tour. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 820		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered	01440		

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01440	Continued From page 19 nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-B was hired June 09, 2022, and provided direct cares for the residents of the facility. ULP-B's record did not include documentation of direct supervision by an RN within 30 days of	01440		

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01440	Continued From page 20 ULP-B performing delegated nursing tasks, including medication administration. On January 05, 2022, at 8:30 a.m., ULP-B was observed administering medications to R1. On January 06, 2022, at 1:45 p.m., direct of nursing, who was also the licensed assisted living director (DON/LALD)-A verified ULP-B's record does not include 30-day supervision of medication administration or other delegated tasks. The licensee's Staff Competency policy indicated, " The Clinical Nurse Supervisor will meet with the staff member to develop and document a plan with time frames for retraining or additional education. Staff members may not perform delegated tasks which they have not demonstrated competence.", the policy does not address the required direct supervision of staff performing a delegated task within 30 days of providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

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01620	Continued From page 21 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment for two of two residents (R1 and R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread 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: R1 R1 was admitted to the facility on August 24,	01620		

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01620	Continued From page 22 2021. R1's Service Plan Agreement, dated August 25, 2021, indicated R1 received services for assistance with medication administration, assistance with activities of daily living (ADLs), housekeeping, laundry, and meals. R1's record included Comprehensive Home Care Resource Sample Monitoring and Reassessment 14 days visit and 90 days visit dated September 08, 2021; November 24, 2021; and ECP asses needs 6 Month Assessment dated February 20, 2022. R1's record lacked documentation of a resident reassessment within 90 calendar days of the previous assessment. R2 R2 was admitted to the facility on February 04, 2022. R2's Service Plan Agreement, dated February 04, 2022, indicated services included medication administration. R2's record included ECP Assess Needs Initial assessment; 30 days assessment;90 days assessment dated February 05, 2022; March 04,2022; and May 19, 2022. R2's record lacked documentation of a resident reassessment within 90 calendar days of the previous assessment. On January 06, 2023 at 1:45 p.m., direct of nursing, who was also the licensed assisted living director (DON/LALD) - A confirmed R1 and R2's record lacked ongoing reassessment within 90 calendar days of the previous assessment. No further information was provided.	01620		

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01620	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01650		

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01650	Continued From page 24 review, the licensee failed to ensure the resident service plan included the required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted to the facility on August 24, 2021. R2. R1's service plan, dated August 25, 2021, indicated the resident received medication management services, 24 hours supervision, need some assistance with self care, laundry, housekeeping, and meals. R2 R2 was admitted to the facility on February 04, 2022. R2's Service Plan Agreement, dated February 04, 2022, indicated services included medication administration, 24 hours supervision, need some assistance with self care, laundry, and housekeeping. On January 05, 2023, at 8:30 a.m., and 8:45 a.m., unlicensed personnel (ULP)-B was observed administering medications to R1 and R2. R1 and R2's service plan lacked the following required contents; - the fees for services, and the frequency of each service, according to the resident's current	01650		

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01650	Continued From page 25 assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On January 06, 2023 at 1:45 p.m., direct of nursing, who was also the licensed assisted living director (DON/LALD) - A confirmed R1 and R2's service plans lacked required content. The licensee's Service Plans policy dated August 01, 2021, indicated " the service plan must include a contingency plan that includes the followings; A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party, the fees for services and the frequency or each service, according to the resident's current review or assessment and resident preferences, the identification of the staff or categories of staff who will provide the services, and the schedule and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	4756 DECATUR AVENUE NORTH NEW HOPE, MN 55428

(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
01650	Continued From page 26 methods or monitoring reviews or assessments of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=D	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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 27 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1). 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: R1's service plan, dated August 25, 2021, indicated the resident received medication management services. R1's medication list dated February 22, 2022, included pain medication, depression medication,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	4756 DECATUR AVENUE NORTH NEW HOPE, MN 55428

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01730	Continued From page 28 and agitation or mood disorder medication. R1's 6 month assessment dated February 20, 20222, noted R1 receives medication management plan, however R1's record lacked a medication management plan to include required content noted below: - a statement describing the medication management services that will be provided; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - identification of medication management tasks that may be delegated to unlicensed personnel; and On January 06, 2023, at 2:00 p.m. director of nursing, who was also the licensed assisted living director (DON/LALD)-A confirmed R1's record lacked evidence of a medication management plan to include the above noted content. The licensee's Service Plan for Medication Management policy dated August 01, 2021 indicated "The written Medication Management Plan includes the following provisions. - a statement describing the medication management services that will be provided; - 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 or person(s) responsible for monitoring medication supplies and ensuring refills are ordered timely; - description of medication management tasks to be delegated to unlicensed personnel;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	4756 DECATUR AVENUE NORTH NEW HOPE, MN 55428

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01730	Continued From page 29 -plans for staff notifying the licensed health professional when/If a problem with medication management services arises; and - Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions." No further information was 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 hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02040	Continued From page 30 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 January 5, 2023, at approximately 12:30 p.m., records were provided for review. Records were reviewed by survey staff on January 5, 2023, between 12:30 p.m. and 1:30 p.m. A hazard vulnerability assessment or safety risk assessment was requested by survey staff but not provided. On January 5, 2023, at approximately 1:40 p.m., the director of nursing who was also the licensed assisted living director (DON/LALD)-A verified that the licensee had not completed a hazard vulnerability or safety risk assessment of the physical environment on and around the property for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *01/06/23*
Time: 11:00:57
Report: 1029231003

Food and Beverage Establishment Inspection Report

Location:
New Life Health Service
4756 Decatur Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0037805
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6122000112
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

CFPM certificate not posted. Instructed Rodney to post his certificate.

Comply By: 01/09/23

Surface and Equipment Sanitizers

chlorine: = 50 ppm at Degrees Fahrenheit
Location: spray bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: milk
Temperature: 34 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

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

Conducted inspection at New Life Service located at 4756 Decatur Avenue North, New Hope, MN 55428. Inspection conducted in the presence of Rodney Cline, PSE/Health Manager & CFPM, and other staff members. Discussed employee illness reporting and exclusion procedures, foodborne illness prevention and mitigation, and other general food safety practices with Rodney.

Establishment serves 5 non-highly susceptible population residents. The kitchen floor was laminate tile, and ceiling textured but painted for durability and cleaning. The walls were smooth and painted dry wall-like

material with slight chipping and pitting in the paint. The countertops were laminate, and the cabinetry and drawers were wood/faux wood with either and painted, laminated, polyurethane covered, or exposed surfaces. I instructed Rodney to have the paint on the walls repaired and to make sure any of the wood/faux wood surfaces in the kitchen are covered with a material to make them smooth, durable, easily cleanable, and non-absorbent.

I also instructed Rodney to post his CFPM certificate.

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 1029231003 of 01/06/23.

Certified Food Protection Manager: Rodney Neil Cline

Certification Number: FM10892 Expires: 10/24/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Rodney Cline
PSE/Health Manager

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231003

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	1	Date	01/06/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:00:57
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
New Life Health Service	4756 Decatur Avenue North	New Hope, MN	55428	6122000112

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037805		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls: _____

Person in Charge (Signature) **Date:** 01/09/23

Inspector (Signature)