Electronically Delivered

March 22, 2024

Licensee
Bobby's House
9200 James Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL34949015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 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.

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.

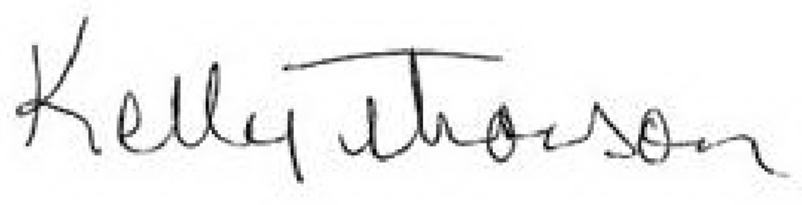
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	34949	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOBBY'S HOUSE	9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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: SL34949015 On March 4, through March 6, 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 3 residents; all receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. The licensee further failed to post the staffing schedule in a central location. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	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 potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of five residents and had a current census of three residents. On March 4, 2024, at 1:30 p.m., the surveyor observed the common areas of the facility and noted the lack of a 24-hour staffing schedule. On March 4, 2024, at 11:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the staffing plan gets evaluated often, but nothing is documented, there is nothing in writing. LALD/CNS-A further stated she was not aware of the statute that it needed to be done. The licensee's Staffing policy dated August 1, 2021, indicated the clinical nurse supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet resident's needs at all times, including reasonably foreseeable needs. The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. The schedule is posted at the beginning of the shift in a central location, accessible to staff, residents, volunteers, and the public.	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 550	Continued From page 4	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 550		

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0 550	Continued From page 5 The findings include: The licensee lacked a posting of the grievance procedure, including the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. On March 4, 2024, at 1:30 p.m.., the surveyor observed the entry area and common areas within the facility and noted there was no required posting of the grievance procedure. On March 4, 2024, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were aware of the requirements of the missing posting and did not have a reason why the complaint and grievance procedure was not posted. The licensee's Grievance policy dated August 1, 2021, indicated a copy of the grievance procedure is conspicuously posted in the residence with the following information, name, telephone number, and email contact information for the individuals who are responsible for handling resident complaints. Contact information for the state and any regional Office of Ombudsman for Long Term Care. Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. Contact information for the Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		

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0 640	Continued From page 6	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the residents). The findings include:	0 640		

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0 640	Continued From page 7 On March 4, 2024, at 1:30 p.m., the surveyor observed the common areas of the facility and noted there was no required posting of information for reporting suspected crime and maltreatment to include the 911 emergency number and the reporting number for the Minnesota Adult Abuse Reporting Center. On March 4, 2024, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were aware of the requirements of the posting and did not have a reason as to why the posting was missing. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated contact information for the MAARC (Minnesota Adult Abuse Reporting Center) shall be posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 8 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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 the residents). The findings include: The licensee's undated EPP lacked documentation including all the required elements of: - annual reviews/updates of plan - missing resident quarterly review - program patient population	0 680		

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0 680	Continued From page 9 - process for collaboration - annual review/update on policies and procedures - policies and procedures for volunteers - roles under a waiver declared by secretary - methods for sharing information On March 4, 2023, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were not aware of all the required elements of appendix z. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated [the Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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	0 780		

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0 780	Continued From page 10 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: Based on observation and interview, the licensee failed to provide smoke alarms inside all sleeping rooms and interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Interconnection	0 780		

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0 780	Continued From page 11 On a facility tour on March 5, 2024, at 10:00 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. None of the smoke alarms were interconnected with other alarms throughout the facility when the test button was activated. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. Alarms receiving power from the building electrical system that are replaced are required to continue receiving power from the building electrical system. Additional alarms may be battery operated but are required to be interconnected with the alarms powered by the building electrical system. During the tour the smoke alarms were tested and LALD/CNS-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. Outside Sleeping Rooms On the same tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of all sleeping rooms in the basement of the facility. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms. During the tour LALD/CNS-A, verified smoke alarms were not installed outside in the immediate vicinity of resident rooms number 3, 4 and 5 in the basement of the facility.	0 780		

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0 780	Continued From page 12 TIME PERIOD FOR CORRECTION: One (1) day.	0 780		
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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 a facility tour on March 5, 2024, at 10:00 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, the surveyor made the following observations of facility	0 800		

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	34949	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOBBY'S HOUSE	9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

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0 800	Continued From page 13 hazards and disrepair: The battery was removed, and the alarm appeared older than ten years from date of manufacture in the sunroom. Smoke alarms are required to be maintained with back up batteries according to manufactures instructions. Smoke alarms are required to be replaced every ten years from the manufacture date listed on the back of the smoke alarm. The smoke alarm was beeping indicating a dead battery in resident room number 5. Smoke alarms are required to be maintained according to manufactures instructions and Minnesota Fire Code in Minnesota Rules Chapter 7511. A hole was observed in the drywall of the exterior wall near an electrical outlet in resident room number 1. Walls are required to be maintained free of holes and damage to the interior drywall finish. The bottom window sash would not stay up on its own when opened in resident room number 2. The same window was also missing the window screen. Windows are required to be maintained as designed and installed at the time of construction approval. The electrical power cord was routed through the wall powering the building security system in the kitchen. Electrical power cords and electrical wiring is required to be used and installed according to manufactures installation instructions and Minnesota Electrical Code requirements. Minnesota electrical licensing requirements apply for the person completing electrical work in Minnesota.	0 800		

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0 800	Continued From page 14 The door closer was missing on the front main entry/ exit storm door. Doors are required to be maintained according to manufactures installation instruction as installed at the time of construction. During a facility tour on March 5, 2024, at 10:30 a.m., LALD/CNS-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 15 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 5, 2024, at 9:15 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP undated, failed to include the	0 810		

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0 810	Continued From page 16 following: The location and number of resident sleeping rooms indicated on the evacuation floor plan. The number and location of resident rooms is required to be included on the floor plan to be used by occupants for direction and communication in the event of a fire or similar emergency. The FSEP did not identify specific fire protection actions for residents evident by not including in writing in the FSEP, procedures for residents to take in the event of a fire or similar emergency. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include the evacuation status and unique and unusual needs for each resident in a written document in the plan and available for immediate use. During an interview on March 5, 2024, at 9:30 a.m., LALD/CNS-A stated resident procedures required during a fire or similar emergency were not included in writing in the FSEP and evacuation status for each individual resident was not included in writing with the plan and available for immediate use by employees. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation training was offered to residents as required.	0 810		

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0 810	Continued From page 17 Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation training based on the facility FSEP was provided to the employees as required. During an interview on March 5, 2024, at 9:35 a.m., LALD/CNS-A stated documentation was not available for training of residents and employees. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation fire and evacuation drills were completed by employees as required. During an interview on March 5, 2024, at 9:40 a.m., LALD/CNS-A stated documentation was not available indicating drills were completed by employees as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must	0 820		

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0 820	Continued From page 18 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, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 5, 2024, at 10:35 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, it was observed that used cigarette buts were discarded outside near the grade level wood deck between the house and deck. An appropriate dispenser was provided in the location but there were several piles of cigarette buts discarded outside the dispenser next to the house and wood deck. Cigarette buts are required to be discarded in appropriate containers in accordance with the facility smoking policy. A double keyed deadbolt lock requiring a key to	0 820		

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0 820	Continued From page 19 open from the inside was installed on the exit door from the garage to the exterior of the building. The door leading from the garage into the house also had a lock requiring a key to enter from the garage into the house. All spaces are required to have a minimum of one exit from the space that can be operated without the use of keys, tools, or special knowledge for the purpose of exiting according to Minnesota Fire Code in Minnesota Rules Chapter 7511. The garage contains combustible storage from floor to ceiling that is material from the owner of the building and does not belong to the licensee. Combustible storage not related to or used by the facility is required to be reduced and removed from the facility. These deficient conditions were visually verified by LALD/CNS-A, accompanying on the tour. TIME PERIOD FOR CORRECTION: one (1) days.	0 820		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under	01290		

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01290	Continued From page 20 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 5, 2024, at 8:15 a.m., the surveyor observed ULP-B provide medication administration to R1. ULP-B was hired December 1, 2021, to provide assisted living services. ULP-B's employee record contained a background study dated August 6, 2021, associated to the corporate HFID number 32559. ULP-B's employee record lacked evidence the licensee submitted a background study for ULP-B under the current HFID number 34949. On March 6, 2024, at 10:50 a.m., licensed assisted living director/clinical nurse supervisor	01290		

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01290	Continued From page 21 (LALD/CNS)-A stated ULP-B was fingerprinted upon hire and cleared the comprehensive background study, ULP-B has not been affiliated with the new license. They did go through the process with net study to affiliate but is not sure why the paperwork is reading the umbrella company name instead of the facility name. LALD/CNS-A further stated they thought the affiliation was complete and did not realize the umbrella name was on the background study. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated the employment process includes the following: the criminal background check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: i. the director or designee is responsible for initiating the criminal background study for new employees ii. NetStudy 2.0 (or current version) will be used for the background check iii. the employee will be directed to locations established by DHS to obtain fingerprint scans iv. employees will be instructed that photographic identification will be required. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition	01370		

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01370	Continued From page 22 to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed for one of one employee (unlicensed personnel (ULP)-B).	01370		

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01370	Continued From page 23 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 began employment on December 1, 2021, to provide direct care services. ULP- was observed providing direct care services to residents on March 5, 2024. ULP-B's employee record lacked documentation of the following required training to be completed by ULP: -documentation requirements for all services provided -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family On March 6, 2024, at 10:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not sure how or why those two classes were missed when she assigned ULP-B's classes in Educare (online training program) but will assign them right away. The licensee's Staff Competency policy dated August 1, 2021, indicated: Training and competency evaluations for all ULP's include the following: -Documentation requirements for all services	01370		

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01370	Continued From page 24 provided -Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) used the uniform assessment tool for ongoing assessments and monitoring 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 4, 2024, at 11:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee completed initial, 14-day, 90-day, and change in condition assessments. R1 was admitted and began receiving services on March 10, 2023. R1's record included an initial comprehensive assessment dated March 10, 2023, a 14-day assessment dated March 24, 2023, and 90-day assessments dated June 22, 2023, September 20, 2023, and December 19, 2023. R1's 14-day and 90-day assessments did not include the following required elements on the uniform assessment tool: -the resident's personal lifestyle preferences, including sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the	01620		

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BOBBY'S HOUSE	9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

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01620	Continued From page 26 resident's quality of life, spiritual and cultural preferences, and advance health care directives and end-of-life preferences - activities of daily living, including toileting pattern, dressing, grooming, bathing, and personal hygiene, mobility, including ambulation, transfers, and assistive devices and eating, dental status, oral care, and assistive devices and dentures. - instrumental activities of daily living, including housework and laundry and transportation - physical health status, including a review of relevant health history and current health conditions including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities and life threatening, infectious conditions, a review of medications, a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a postacute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months, weight, and initial vital signs if indicated by health conditions or medications - emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, effective medication treatment and non medication interventions - cognition, including a review of any neurocognitive evaluations and diagnoses - communication and sensory capabilities, including speech, assistive communication and sensory devices including hearing aids, and the ability to understand and be understood -nutritional and hydration status and preferences	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34949	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOBBY'S HOUSE	9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01620	Continued From page 27 - list of treatments, including type, frequency, and level of assistance needed - nursing needs, including potential to receive nursing-delegated services - risk indicators including risk for falls including history of falls, emergency evaluation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking, including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician - who has decision making authority for the resident including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker under subitem (1) - the need for follow-up referrals for additional medical or cognitive care by health professionals On March 5, 2024, at 11:43 a.m., LALD/CNS-A stated she was not aware of the uniform assessment tool. She was using the forms they had gotten from their consultant company and did not know the assessment forms did not meet statutory requirements. They have been using the same forms for all resident assessments. The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility must develop a uniform assessment tool to include all the required elements.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34949	A. BUILDING: _____ B. WING _____	03/06/2024

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BOBBY'S HOUSE	9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

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01620	Continued From page 28 The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse (RN) will conduct a comprehensive assessment for all residents admitted to [the facility] to determine services required and to develop an individualized care plan for staff to implement. The assessment addressed the resident's physical, mental, and cognitive needs. The RN will conduct a comprehensive assessment utilizing a uniform assessment tool. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of one resident (R3) who utilized oxygen. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34949	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 29 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 5, 2024, at 11:00 a.m., the surveyor observed three unsecured oxygen tanks in R3's room. On March 5, 2024, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the oxygen tanks were delivered without racks and was unsure why. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. The licensee's Equipment Safety policy dated August 1, 2021, indicated the manufacturer's specifications and guidelines are followed for equipment operation and safety. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34949	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOBBY'S HOUSE	9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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
03090	Continued From page 30 maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On March 4, 2024, at 9:40 a.m., upon entrance to the facility, the surveyor observed the lack of an electronic monitoring notice to visitors posted. On March 4, 2024, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were aware of the requirements for the electronic monitoring posting and did not know why it was not posted. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated [the facility] will post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities."	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34949	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOBBY'S HOUSE	9200 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

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03090	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *03/04/24*
Time: 12:00:52
Report: 1029241067

Food and Beverage Establishment Inspection Report

Location:
Bobby'S House
9200 James Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0037499
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7632229503
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Temperature abused TCS foods identified in refrigerator. Unclear if temp abuse was mechanical, behavioral, or both. Temp abused items discarded. Internal thermometer read 41°F. Instructed reps to monitor and adjust as needed.

Comply By: 03/04/24

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

Sliced meats without date marking. Corrected during inspection. Instructed representatives to date mark things like deli meats. Listeria monocytogenes was discussed.

Comply By: 03/04/24

4-300 Equipment Numbers and Capacities

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

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

No small diameter probe thermometer. Instructed representative to obtain small diameter probe thermometer.

Comply By: 03/22/24

2-100 Supervision

2-102.12DMN

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

CFPM certificate not posted. Instructed representative to post.

Comply By: 03/04/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

Damp wiping cloth not held in sanitizer solution. Instructed representative to hold damp cloths in sanitizer.

Comply By: 03/04/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Hole in sink. Gap at sink counter juncture. Cabinet door missing. Instructed representative to repair or replace.

Comply By: 08/30/24

Food and Equipment Temperatures

Process/Item: unsalted butter
Temperature: 47 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: milk
Temperature: 46 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: sliced ham
Temperature: 38 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

Process/Item: sliced ham
Temperature: 40 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

Process/Item: sliced chicken
Temperature: 40 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

Process/Item: sliced roast beef
Temperature: 40 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

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

Inspection conducted with Natalie Campbell, RN and Person-in-Charge, and other serving and food preparation staff members. All identified issues were addressed with Natalie and other staff members throughout the inspection.

Topics discussed included:

-receiving and cold holding temperatures
-cooking, and hot holding times and temperatures
-cooling times and temperatures
-equipment standards and maintenance
-chemical and heat sanitizing and establishment sanitation
-employee hygiene and illness exclusion procedures
-barehand contact with ready to eat foods and glove/utensil use
-common reportable foodborne illness pathogens
-demonstration and dissemination of food safety knowledge
-recognizing and discarding contaminated foods

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 1029241067 of 03/04/24.

Certified Food Protection Manager: Thomasia Evelyn Naya

Certification Number: FM110134 Expires: 03/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Natalie Campbell
RN & Person-in-Charge

Signed: _____

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

Report #: 1029241067

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	3	**Date**	03/04/24
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:00:52
Legal Authority MN Rules Chapter 4626		**Time Out**	

Bobby'S House	**Address** 9200 James Avenue North	**City/State** Brooklyn Park, MN	**Zip Code** 55444	**Telephone** 7632229503
License/Permit # 0037499	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41	X	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	X	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:** 03/07/24

Inspector (Signature) Jason L McClimint