Electronically Delivered

December 18, 2024

Licensee
Wellness Group Home Corporation
2606 64th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL36257015

Dear Licensee:

On November 18, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 30, 2024, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 8, 2024

Licensee
Wellness Group Home Corporation
2606 64th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL36257015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 30, 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.

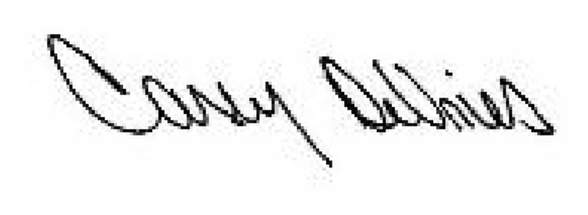
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36257	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLNESS GROUP HOME CORPORATIO	2606 64TH AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: SL36257015-0 On August 26, 2024, through August 30, 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 three active residents; three of whom received services under the Assisted Living license. An immediate correction order was identified on August 29, 2024, issued for SL3625015-0, tag identification 0820.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	0 490		

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0 490	Continued From page 1 (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that creates opportunities for active participation in the community at large. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 490		

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0 490	Continued From page 2 The findings include: On August 26, 2024, at 1:30 p.m., during the entrance conference, owner/ house manager (O/HM)-B responded yes when the surveyor asked if the licensee provided a daily program of social and recreational activities. O/HM-B stated they had some activities, but residents prefer to go out on their own. On August 26, 2024, at 2:00 p.m., during a tour of the facility, the surveyor observed there was not an activity calendar posted in any part of the facility. On August 26, 2024, at 2:00 p.m., O/HM-B stated licensee did not have any scheduled activities and did not post an activity calendar. On August 26, August 27, and August 29, 2024, the surveyor did not observe any activities planned or offered to the residents. On August 27, 2024, at 1:20 p.m., R4 stated they had requested planned activities at resident council meetings. R4 stated they had requested a regular schedule for activities such as playing cards, board games, or to have a movie night where everyone comes together. R4 stated they had made this request several times but had never seen an activity schedule or been told of any planned activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		

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0 630	Continued From page 3	0 630		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed or updated as needed to include the required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3 was admitted to the licensee and began receiving assisted living services on September 16, 2022.	0 630		

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0 630	Continued From page 4 R3's diagnoses included fetal alcohol syndrome, impulse control disorder, persistent mood disorder, mild intellectual disability, attention deficit disorder, post-traumatic stress disorder, and Type 2 Diabetes. R3's Service Plan- Addendum to Contract, dated October 17, 2022, indicated R3 received medication administration, blood glucose monitoring, assistance with dressing, grooming, incontinence care, bathing reminders, housekeeping, laundry, behavior management, safety checks, and shopping. R3's record contained an IAPP, dated September 16, 2022, that indicated R3 was not at risk of abusing others. R3's record contained an assessment, dated August 15, 2024, that indicated R3 was not at risk of abusing others. Incident Report, dated January 7, 2024, indicated at 10:00 a.m., R3 was upset waiting for a family member to bring them money. R3 was pacing around the kitchen while waiting and holding another resident's cereal box. When staff asked R3 to put down the cereal box, R3 used "foul language", then threw kitchen utensils and a napkin holder across the room at staff. R3 called the police to report staff falsely accusing them of taking cereal box that belonged to another resident. Incident Report, dated February 20, 2024, indicated at 8:35 p.m., R3 could not find lottery ticket they thought was left on kitchen table. R3 struck his shoe against the wall and then threw the shoe at staff. Police were called.	0 630		

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0 630	Continued From page 5 Incident Report, dated February 23, 2024, indicated at 7:25 p.m., R3 yelled at staff that they needed apple juice. Staff requested R3 ask instead of yell. R3 threw a bowl at staff and continued to yell until police arrived at the facility. R3's progress note, dated March 4, 2024, at 1:31 p.m., documented by clinical nurse supervisor (CNS)-A indicated R3 continued "to be aggressive towards others" and did not respect personal boundaries at the facility or out in the community. R3's progress note, dated March 10, 2024, at 4:35 p.m., documented by owner/ house manager (O/HM)-B indicated R3 had been at a gas station with a friend. While the friend was using the restroom, R3 walked up to someone else's car and started hitting the window. Police and paramedics arrived on the scene and transported R3 to a hospital emergency department. Incident Report, dated March 17, 2024, indicated at 10:31 p.m., R3 used inappropriate language and punched staff several times. R3 took a small metal box that stored medication cart keys and smashed it onto the floor. Police were called. R3's progress note, dated June 2, 2024, at 4:20 p.m., documented by O/HM-B indicated police drove R3 home to facility and reported R3 had been inappropriately confronting people at a grocery store. R3's progress note, dated July 27, 2024, at 11:00 p.m., documented by O/HM-B indicated R3 was seen in the hospital emergency department for a head injury following an altercation at a gas station. O/HM-B's documentation indicated R3 instigated the situation by throwing a drink at	0 630		

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0 630	Continued From page 6 another person. The other person then hit R3 in the head with an unspecified object. On August 26, 2024, at 1:00 p.m., during the entrance conference, CNS-A stated the IAPP was completed at time of admission and updated when needed or with each comprehensive assessment. On August 27, 2024, at 11:50 a.m., CNS-A stated they had not updated the IAPP to indicate R3 was at risk of abuse to others because they did not believe R3 would harm other residents. CNS-A stated R3 was verbally aggressive and abusive to staff but had not been to other residents. CNS-A did not know if community members R3 had been in physical altercations with were vulnerable adults or not. The licensee's Vulnerable Adult policy, dated July 28, 2021, indicated licensee would establish an individual abuse prevention plan for each vulnerable adult receiving assisted living services. The plan would contain an individualized assessment of the resident's susceptibility to abuse by another individual, risk of abusing others, and risk of self-abuse and neglect. The plan would include statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The plan would be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 650	Continued From page 7	0 650		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content of training and competency for continuous invasive glucose sensor monitor for two of two employees (owner/ house manager (O/HM)- B and unlicensed personnel (ULP)-C). 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	0 650		

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0 650	Continued From page 8 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: O/HM-B O/HM-B had a hire date of July 26, 2019; O/HM-B provided direct services to residents. On August 29, 2024, at 10:53 a.m., the surveyor observed O/HM-B assist R3 with checking blood glucose level by scanning Freestyle Libre sensor on R3's upper left arm with a phone to obtain blood glucose level. O/HM-B stated they learned how to use the Freestyle Libre from clinical nurse supervisor (CNS)-A. ULP-C ULP-C had a hire date of May 4, 2024; ULP-C provided direct services to residents. O/HM-B and ULP-C's employee records lacked documentation of training and competency for the Freestyle Libre (continuous invasive glucose sensor monitor). On August 29, 2024, at 10:04 a.m., CNS-A stated they learned how to use the Freestyle Libre device from reading the written instructions that came with the device and by phone from the pharmacy that provided the device. CNS-A stated they held a staff meeting and provided training for all ULPs when R3 first got the device. CNS-A stated they observed staff one by one as they were working to ensure competency of using the Freestyle Libre for blood glucose monitoring. CNS-A stated they did not document the meeting	0 650		

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0 650	Continued From page 9 or observations. The licensee's Personnel Records policy, dated July 28, 2021, indicated a record of each employee that provided assisted living services would be maintained. This record would include training and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding 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.	0 680		

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0 680	Continued From page 10 (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 residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP, last reviewed on May 20, 2024, lacked evidence of the following required content: - reviewed missing resident plan quarterly; - Policy and procedure (P/P) for ensuring food, water, medical supplies, and pharmaceutical supplies; - P/P for alternate sources of energy to maintain temperatures to protect resident health/safety, safe/sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems, and sewage and waste disposal; - P/P for system to track the location of on-duty staff and sheltered residents; - P/P to address role of facility under a waiver declared by the Secretary; and	0 680		

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0 680	Continued From page 11 - written communication plan that included names and contact information of staff and residents' physicians. On August 27, 2024, at 2:30 p.m., owner/housing manager (O/HM)-B stated they believed the facility had up to one month of medications and three days of food resources for current residents at any time. O/HM-B was unsure about water and medical supplies and stated they did not have a system of tracking what supplies were available on hand. O/HM-B stated they had flashlights in the kitchen for an emergency, but the flashlights would need new batteries. On August 27, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated the missing resident policy was reviewed annually. The licensee's Emergency Preparedness policy, dated July 28, 2021, indicated they would 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 disrupted services. No further information was 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:	0 780		

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	36257	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLNESS GROUP HOME CORPORATIO	2606 64TH AVENUE NORTH BROOKLYN CENTER, MN 55430

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0 780	Continued From page 12 (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: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code provisions. 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: On a facility tour on August 29, 2024, from 9:30 a.m. to 11:00 a.m., with owner/ house manager	0 780		

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0 780	Continued From page 13 (O/HM)-B, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: There was not a carbon monoxide alarm provided outside and within 10 feet of the sleeping room in the basement. Carbon monoxide alarms are required to be installed outside and within 10 feet of all sleeping rooms in the facility in accordance with current Minnesota Fire Code. During a facility tour on August 29, 2024, at 11:00 a.m., O/HM-B, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	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, 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	0 790		

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0 790	Continued From page 14 failed to maintain fire extinguishers as required throughout the facility. This deficient condition had the ability 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) 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 a facility tour on August 29, 2024, from 9:30 a.m. to 11:00 a.m., it was observed that the required fire extinguisher had a manufacture date of 2021, and no documentation was provided of required annual service. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility in accordance with current Minnesota Fire Code. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on August 29, 2024, at 11:00 a.m., O/HM-B, verified this deficient finding.	0 790		

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0 790	Continued From page 15 TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		
0 800 SS=E	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 affect more than a limited number of 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 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). Findings include: On a facility tour on August 29, 2024, from 9:30 a.m. to 11:00 a.m., with owner/ house manager	0 800		

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0 800	Continued From page 16 (O/HM)-B, the surveyor made the following observations of facility disrepair: The light fixture cover was missing, and bulb was flashing on the ceiling light in the hallway near resident rooms 1, 2, and 3. Electrical light fixtures are required to be maintained with the cover as designed by the manufacturer. The wood gate outside on the side of the garage was removed from the hinges and leaning on the wall in the walkway to the front yard. The screen door on the patio door leading to the deck from the kitchen area was out of adjustment and hard to open. The electrical fixture cover and bulbs were missing, from the ceiling light fixture in the laundry room upstairs. Electrical light fixtures are required to be maintained with the cover as designed by the manufacturer. During a facility tour on August 29, 2024, at 11:00 a.m., O/HM-B, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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	0 820		

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0 820	Continued From page 17 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 or a large portion of the 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, 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). Findings include: On a facility tour on August 29, 2024, from 9:30 a.m. to 11:00 a.m., with owner/ house manager (O/HM)-B, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 2, and 3. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 1, emergency escape and rescue clear window opening measurements	0 820		

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0 820	Continued From page 18 were 32 inches wide, 15 inches in height, and 480 square inches in openable area. The window was measured with O/HM-B, and the surveyor present. The window did not meet the minimum requirements for clear opening height and total square inch area. Resident sleeping room 3, emergency escape and rescue clear window opening measurements were 32 inches wide, 15 inches in height, and 480 square inches in openable area. The window was measured with O/HM-B, and the surveyor present. The window did not meet the minimum requirements for clear opening height and total square inch area. UNOCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 2, emergency escape and rescue clear window opening measurements were 32 inches wide, 15 inches in height, and 480 square inches in openable area. The window was measured with O/HM-B, and the surveyor present. The window did not meet the minimum requirements for clear opening height and total square inch area. The surveyor explained to O/HM-B, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve	0 820		

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0 820	Continued From page 19 the total square inch area of 648 square inches. These deficient conditions were visually verified by O/HM-B, accompanying on the tour. The surveyor explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for three of three residents (R2, R3, and R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 970		

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0 970	Continued From page 20 The findings include: On August 26, 2024, at 3:00 p.m., owner/ house manager (O/HM)-B provided the surveyor with the current assisted living contract in use for new residents. O/HM-B confirmed no changes had been made to the contract and it was the same version used for the current three resident and in the past for any discharged residents. R2 R2 was admitted to the licensee and began receiving assisted living services on July 14, 2023. R3 R3 was admitted to the licensee and began receiving assisted living services on September 16, 2022. R4 R4 was admitted to the licensee and began receiving assisted living services on May 29, 2023. R2, R3, and R4's Assisted Living Contracts, included on page four, a section titled Primary Services. Number six of this section, titled Emergency Services/Staff Availability indicated license would not be liable for resident safety once the resident had departed the premises. Number seven of this section, also on page four, indicated resident rooms had locks, and that if the resident chose not to lock their valuables, the resident assumed liability for those valuables. R2, R3, and R4's Assisted Living Contracts, included on page eight, a section titled Financial Arrangements- Billing and Payment Procedures	0 970		

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0 970	Continued From page 21 and Requirements. Part five of this section indicated the resident would pay all costs and expenses, including reasonable attorney's fees and court costs, incurred by licensee in collecting amounts past due under the contract. R2, R3, and R4's Assisted Living Contracts, included on page ten, a section titled Term and Termination. Part seven of this section indicated the resident would be liable for all charges accrued or incurred prior to the effective date of termination, regardless of whether the resident vacated the room prior to the effective date of termination and regardless of whether or the resident terminated the contract. In addition, licensee reserved the right to remove the resident's property and indicated the resident would pay the cost of storage of any property remaining in the room after the termination of the contract. R2, R3, and R4's Assisted Living Contracts, included on page eleven and twelve, a section titled Miscellaneous Provisions. Part one of this section indicated the resident shall always maintain his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to licensee upon request. The section included resident acknowledgement that licensee was not an insurer of the resident's person or property. The resident agreed to release licensee from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of licensee or its employees or agents. Part four of this section indicated if the property is	0 970		

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0 970	Continued From page 22 deemed uninhabitable due to damage beyond reasonable repair, and said damage was due to the negligence of the resident, the resident shall be liable to licensee for all repairs and for the loss of income due to restoring the premises back to a livable condition in addition to any other losses that can be proved by licensee. R2, R3, and R4's Assisted Living Contracts, included on page fourteen, a section titled Liability indicated "the resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced". On August 29, 2024, at 5:30 p.m., O/HM-B stated they were not aware the contract did not meet requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01050 SS=A	144G.52 Subd. 8 Content of notice of termination The notice required under subdivision 7 must contain, at a minimum: (1) the effective date of the termination of the assisted living contract; (2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale;	01050		

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01050	Continued From page 23 (3) a detailed explanation of the conditions under which a new or amended contract may be executed; (4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted; (5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55; (6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination; (7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination; (8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and (9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required content of a written termination notice for one of one resident (R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	01050		

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01050	Continued From page 24 affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4 was admitted to the licensee and began receiving assisted living services on May 29, 2023. R4's diagnoses included depression, hypertension, acid reflux. R4's Service Plan- Addendum to Contract, dated May 29, 2023, indicated R4 received medication set up, medication reminders, assistance with dressing, grooming, bathing reminders, housekeeping, laundry, and behavior management. R4's Assisted Living Contract was signed on May 29, 2023. On August 27, 2024, at 1:20 p.m., during an interview about facility services, R4 stated they had recently been served a thirty-day termination notice and they were uncertain if they would have to move out or not. R4 stated they had appealed the notice and were working with someone from the Office of Ombudsman for Long Term Care (OOLTC). On August 27, 2024, at 3:17 p.m., owner/ house manager (O/HM)-B confirmed they had provided R4 with a termination notice. O/HM-B stated they had been trying to help R4 find alternate housing but R4 had declined all the potential options	01050		

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01050	Continued From page 25 looked at. The surveyor requested to review R4's contract termination documentation. On August 29, 2024, at 12:30 p.m., O/HM-B indicated there had been a pre-termination meeting, the termination notice was provided after that, R4 was working with OOLTC and had an appeal pending. O/HM-B stated they were actively speaking with and cooperating with OOLTC. On August 29, 2024, at 12:35 p.m., O/HM-B provided the surveyor with a typed summary of the pre-termination meeting. The summary indicated the meeting was held at the facility on June 18, 2024, and attended by R4, O/HM-B, clinical nurse supervisor (CNS)-A, R4's Cadi case manager, and two additional outside persons. O/HM-B stated the two additional persons were also from Cadi. The summary indicated items discussed included behavioral outburst, communication boundaries, search for alternative housing, grocery shopping and menu concerns, and application of emergency funding to pay for past due rent. R4's Notice of Termination of Assisted Living Contract, dated July 15, 2024, indicated it was a thirty-day termination of housing, that was not expedited, and cited an end date of August 13, 2024. The basis for termination included "due to refusal of medications that the psychiatrist suggested prescribing for you after the assessment, refusal to have an assigned therapist or retain the previous therapist, declining the Hennepin mental health emergency (COPE) services, complaining neighbors and excessive verbal/ physical aggression towards staff". The form had a space to enter conditions required for a new or amended contract. In that	01050		

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01050	Continued From page 26 space the licensee indicated "No". The Notice of Termination of Assisted Living Contract, dated July 15, 2024, lacked the following requirements: - a detailed explanation of the conditions under which a new or amended contract may be executed; and - information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted. On August 29, 2024, at 12:30 p.m., O/HM-B stated they felt like they had tried everything to make it work for R4 and that no additional outside resources could remedy the situation. O/HM-B stated they would continue to work with R4 and OOLTC on finding alternate arrangements. O/HM-B stated licensee would continue to provide housing with services throughout the appeal process. The licensee's Discharge and Transfer of Residents policy, dated July 28, 2021, indicated residents discharged or transferred from licensee would have a coordinated process for discharge or transition to another provider/setting. This process included a written notice of contract termination that would be issued to the resident, the resident's legal representative and the resident's designated representative at least 30 days before the effective date of the termination. The policy did not include what components were required on the thirty-day notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01050		

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01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060		

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01060	Continued From page 28 (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee and began receiving assisted living services on July 14, 2023. R2's diagnoses included limbic encephalitis with seizures and depressive disorder. R2's Service Plan- Addendum to Contract, dated July 17, 2023, indicated R2 received medication administration, assistance with bathing, dressing, grooming, housekeeping, laundry, behavior management, shopping, and transportation. R2's record included an After Visit Summary,	01060		

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01060	Continued From page 29 dated August 25, 2024, which indicated R2 was inpatient at a hospital beginning on August 17, 2024, and was discharged from the hospital on August 25, 2024. R2's Clinical Update Assessment, dated August 26, 2024, indicated R2 returned to licensee on August 25, 2024, following an inpatient hospitalization. R2's record lacked a written notice delivered to the resident or designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to OOLTC when R2 did not return to the facility within four days. On August 29, 2024, at 3:00 p.m., CNS-A stated they had not completed an emergency relocation form for R2's hospitalization. CNS-A stated the Office of the Ombudsman for Long-Term Care had not been notified of R2's hospitalization that extended beyond four days inpatient. CNS-A stated they were not aware of the requirements	01060		

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01060	Continued From page 30 for emergency relocation and ombudsman notification and had not completed either for any hospitalization of facility residents. The licensee's Discharge and Transfer of Residents policy dated July 28, 2021, indicated that in the event of an emergency relocation, the facility would, as soon as possible, provide written notice of Emergency Relocation to the following: - the resident; - the resident's legal representative; - the resident's designated representative; and - the resident's case manager if the resident received home and community-based services. Furthermore, if the resident had been relocated and not returned to the facility within four (4) days, the facility would provide notification to the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in	01500		

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01500	Continued From page 31 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01500		

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01500	Continued From page 32 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees that performed direct services completed all required training components for each twelve months of employment for two of two employees (clinical nurse supervisor (CNS)-A and owner/ house manager (O/HM)-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) 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: CNS-A CNS-A began employment with the licensee on January 1, 2021, to provide oversite to unlicensed personnel and direct services to residents. On August 29, 2024, at 10:32 a.m., the surveyor observed CNS-A prepare and administer medications for R3. CNS-A's employee record lacked training for the following required topics: - review of provider policies and procedures for 2022, 2023, and 2024. O/HM-B	01500		

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01500	Continued From page 33 O/HM-B had a hire date of July 26, 2019, O/HM-B provided direct services to residents. On August 27, 2024, at 10:53 a.m., the surveyor observed O/HM-B prepare and administer medications for R2. O/HM-B's employee record lacked training for the following required topics: - review of provider policies and procedures for 2021, 2022, and 2024. On August 26, 2024, at 4:42 p.m., CNS-A stated the facility policies and procedures were reviewed with each new employee at hire, however they were not aware the policies and procedures were required to be reviewed annually. On August 26, 2024, at 4:42 p.m., O/HM-B stated the policy manual was kept on a shelf in the kitchen that staff had access to review at any time. O/HM-B stated they did expect the staff to review the policy manual routinely but had not communicated this as a specific requirement to staff. O/HM-B stated they had not implemented a formal procedure for annual review of policies, nor provided any direction to staff, and did not have any tracking in place to demonstrate completion of annual policy review for any employees. The licensee's Staff Orientation and Education policy, dated July 28, 2021, indicated all staff providing assisted living services would complete at least eight hours of education for every twelve months of employment. The education topics would include: - review of the organization's policies and procedures related to provision of assisted living services and how to implement them;	01500		

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01500	Continued From page 34 - reporting of maltreatment of adults; - review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - infection control techniques; - effective approaches to use to problem solving in communication; and - principles of person-centered planning and service delivery. In addition, licensee would maintain proof of orientation and education in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to initiate a temporary service plan for one of three residents (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01630		

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01630	Continued From page 35 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: R2 was admitted to the licensee and began receiving assisted living services on July 14, 2023. R2's diagnoses included limbic encephalitis, epilepsy, myoclonus, affective psychosis, and hyponatremia. R2's Service Plan- Addendum to Contract, dated July 17, 2023, indicated R2 received medication administration, assistance with dressing, grooming, bathing reminder, incontinence care, housekeeping, laundry, behavior management, shopping, transportation, and meal assistance. R2's record lacked a temporary service plan. R2's Medication Administration Record (MAR), dated July 2023, indicated R2 received medication administration from facility employees at the following times: - July 14, 2023, at 8:00 p.m.; - July 15, 2023, at 8:00 a.m., 2:00 p.m., and 8:00 p.m., and - July 16, 2023, at 8:00 a.m., 2:00 p.m., and 8:00 p.m. On August 27, 2024, at 10:53 a.m., the surveyor observed owner/ house manager (O/HM)-B prepare and administer medications for R2. On August 29, 2024, at 12:54 p.m., clinical nurse supervisor (CNS)-A stated they remembered completing a pre-admission assessment for R2	01630		

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01630	Continued From page 36 that would have generated a service plan. CNS-A does not recall why the service plan was not printed, signed, and documented as effective until July 17, 2023. The licensee's Service plan policy dated July 28, 2021, indicated that beginning with the date assisted living services are first provided, a service plan would be developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. A temporary service plan and agreement with the resident would be developed if services were initiated and the individualized assessment had not been completed. The temporary service plan would not be effective for more than 72 hours. In addition, the service plan and all revisions would be maintained in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760		

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01760	Continued From page 37 follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 August 26, 2024, at 1:00 p.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated licensee used a pharmacy that delivered medications in bubble packs that contained all medications due at time of each medication pass with the individual medications listed on the back of the bubble pack. CNS-A stated the pharmacy delivered medications monthly. Each bubble pack contained one week of medications. The resident's medication administration record (MAR) listed each medication name, dose, route, and time to be administered. CNS-A stated staff were required to compare the bubble pack label to the MAR to ensure the medications from the pharmacy the same and staff were administering all correct	01760		

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01760	Continued From page 38 medications ordered at that time. CNS-A stated they checked in the medications when they arrived from the pharmacy to make sure they were correct. R3 was admitted to the licensee and began receiving assisted living services on September 16, 2022. R3's diagnoses included fetal alcohol syndrome, impulse control disorder, persistent mood disorder, mild intellectual disability, attention deficit disorder, post-traumatic stress disorder, and Type 2 Diabetes. R3's Service Plan- Addendum to Contract, dated October 17, 2022, indicated R3 received medication administration, blood glucose monitoring, assistance with dressing, grooming, incontinence care, bathing reminders, housekeeping, laundry, behavior management, safety checks, and shopping. R3's prescriber orders, dated November 28, 2023, indicated R3 took tolterodine extended release (ER) 4 milligrams (mg) one capsule by mouth daily at 8:00 p.m. R3's medication administration record (MAR), dated August 2024, indicated R3 took tolterodine ER 4 mg one capsule by mouth daily at 8:00 p.m. The MAR was signed off as administered at 8:00 p.m. by same staff that administered other 8:00 p.m. each day from August 1 to August 28, 2024. On August 29, 2025, at 10:32 a.m., CNS-A prepared and administered medications for R3. CNS-A compared the label on the individual bubble pack from the pharmacy to the MAR. The bubble pack contained the following medications:	01760		

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01760	Continued From page 39 - aripiprazole 10 mg one tablet; - divalproex extended release 500 mg three tablets; - gabapentin 300 mg two capsules; - guanfacine 1 mg one tablet; - haloperidol 5 mg one tablet; - hydroxyzine 50 mg one capsule; - Januvia 100 mg one tablet; - omeprazole 20 mg one capsule; and -tolterodine 4 mg ER one capsule. CNS-A poured the medications from the individual bubble pack into a plastic medication cup and set them on the kitchen table in front of R3. R3 swallowed all the medications from the cup. On August 29, 2024, at 2:50 p.m., CNS-A stated R3's tolterodine ER 4 mg was scheduled for 8:00 p.m., but it was in the bubble pack with the 8:00 a.m. medications. CNS-A stated it had always been in the 8:00 a.m. pack from the pharmacy but scheduled for 8:00 p.m. CNS-A acknowledged that the staff passing 8:00 a.m. medications had been administering the tolterodine with the other morning medications and not signing off on it and the staff passing 8:00 p.m. medications had been signing off on administering the tolterodine but had never administered it. CNS-A stated none of the facility staff had approached CNS-A with a question about the tolterodine. CNS-A acknowledged staff should question a medication not listed on the MAR and a medication listed on the MAR but not administered should not have been signed off as administered. In both situations, CNS-A stated the staff should have called the nurse. The licensee's Medication Administration policy, dated July 28, 2021, indicated the registered nurse (RN) was responsible for assessing	01760		

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	36257	A. BUILDING: _____ B. WING _____	08/30/2024

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01760	Continued From page 40 medications to assure that all medications were current and ordered by the prescriber. In addition, all staff with responsibility for medication administration would have access to information about the medication being administered, including but not limited to the purpose, dosage, route, frequency, instructions related to the medication, side effects, and resident allergies to medications. The licensee's Medication Incidents/Errors policy dated July 28, 2021, indicated licensee would recognize and promptly address medication errors/incidents. The staff member identifying a medication error or incident would promptly report it to the registered nurse and complete a medication incident form. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication set up included the dates of medication set up for one of one resident receiving medication set up (R4).	01770		

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01770	Continued From page 41 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, at 1:00 p.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated one of three residents received medication set up. CNS-A stated they set up R4's medications every two weeks in a pill box. CNS-A stated R4 kept the set-up medications in their room and self-administered them independently. CNS-A stated they documented medication set up in R4's electronic medical record (EMR). R4 was admitted to the licensee and began receiving assisted living services on May 29, 2023. R4's diagnoses included depression, hypertension, and acid reflux. R4's Service Plan- Addendum to Contract, dated May 29, 2023, indicated R4 received medication set up, medication reminders, assistance with dressing, grooming, bathing reminders, housekeeping, laundry, and behavior management. The EMR tracked medication set up on a document titled Med Setup/ Review Summary. The document contained the same information in	01770		

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01770	Continued From page 42 the same format as a medication administration record. On the left side of the document there were entries for each medication that included the name of the medication, quantity of dose, time to be administered, and the route of administration. Across the top, the document included dates for each day of the month and the rest of the area had boxes that corresponded for each medication entry and date of the month where CNS-A documented the date of medication setup and their initials. R4's Med Setup/ Review Summary, dated June 1 to 30, 2024, printed on August 29, 2024, included the following medications scheduled for 8:00 a.m.: - hydrocortisone 2.5 percent external cream applied twice daily for hemorrhoids and - pantoprazole 40 milligrams (mg) one tablet by mouth daily. The following medications scheduled for 9:00 a.m.: - amlodipine besylate 10 mg one tablet by mouth daily; - bupropion XL 300 mg one tablet by mouth daily; - cetirizine 10 mg one tablet by mouth daily; - hydrochlorothiazide 25 mg one tablet by mouth daily; - metoprolol succinate ER 50 mg one tablet by mouth daily; - docusate sodium 100 mg one capsule by mouth twice daily and - nicotine patch 21 mg per 24-hour period unwrap and apply a patch on skin once each day every 24 hours. The following medication scheduled for 8:00 p.m.: - hydrocortisone 2.5 percent external cream applied twice daily for hemorrhoids.	01770		

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01770	Continued From page 43 The following unscheduled as needed medications: - famotidine 20 mg one tablet by mouth twice daily as needed; - methylcellulose fiber therapy one tablespoon by mouth daily as needed for constipation; - nicotine lozenge 2 mg one lozenge by mouth every one hour as needed for nicotine craving; and - polyethylene 17 gram (gr) one packet by mouth once daily as needed for constipation. All of the medications listed on R4's Med Setup/ Review Summary, dated June 1 to June 30, 2024, were documented as set up on May 20, 2024, by CNS-A for June 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10. The rest of the month was blank indicating no medications were set up June for administration June 11 to June 30. R4's Med Setup/ Review Summary, dated July 1 to 31, 2024, printed on August 27, 2024, included the following medication scheduled for 8:00 a.m.: -hydrocortisone 2.5 percent external cream applied twice daily for hemorrhoids. This medication was signed off as included in the set-up medications on July 15, 2024, the rest of the dates were blank. The following medications scheduled for 9:00 a.m.: - amlodipine besylate 10 mg one tablet by mouth daily; - bupropion XL 300 mg one tablet by mouth daily; - cetirizine 10 mg one tablet by mouth daily; - hydrochlorothiazide 25 mg one tablet by mouth daily; and - docusate sodium 100 mg one capsule by mouth twice daily.	01770		

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01770	Continued From page 44 The document lacked documentation of initials and date of set up for the following medications and dates: - amlodipine besylate 10 mg, bupropion XL 300 mg, cetirizine 10 mg, and hydrochlorothiazide on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14. - docusate sodium 100 mg one capsule by mouth twice daily was documented as included with the set-up medications on July 15, 2024, at 9:00 a.m. but no other days in July. R4's Med Setup/ Review Summary, dated August 1 to 31, 2024, printed on August 29, 2024, included the following medication scheduled for 8:00 a.m.: -pantoprazole 40 mg one tablet by mouth daily. The following medications scheduled for 9:00 a.m.: - amlodipine besylate 10 mg one tablet by mouth daily; - bupropion XL 300 mg one tablet by mouth daily; - cetirizine 10 mg one tablet by mouth daily; - hydrochlorothiazide 25 mg one tablet by mouth daily; - metoprolol succinate ER 50 mg one tablet by mouth daily; and - omeprazole 20 mg by mouth daily. The following unscheduled as needed medications: - famotidine 20 mg one tablet by mouth twice daily as needed; - methylcellulose fiber therapy one tablespoon by mouth daily as needed for constipation; - nicotine lozenge 2 mg one lozenge by mouth every one hour as needed for nicotine craving; and - polyethylene 17 gm one packet by mouth once daily as needed for constipation. The document lacked documentation of initials	01770		

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01770	Continued From page 45 and date of set up for the following medications and dates: - pantoprazole 40 mg August 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31; - bupropion XL 300 mg August 28, 29, 30, and 31; - cetirizine 10 mg on August 28, 29, 30, and 31; - metoprolol succinate ER 50 mg on August 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 28, 29, 30, and 31; and - omeprazole 20 mg on August 1, 2,3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25. The following unscheduled as needed medications were documented as included in the set-up medications on the following dates: - famotidine 20 mg on August 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31; - methylcellulose fiber therapy one tablespoon on August 26, 27, 28, 29, 30, and 31; - nicotine lozenge 2 mg one lozenge on August 26, 27, 28, 29, 30, and 31; and - polyethylene 17 gm one packet on August 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. On August 29, 2024, at 4:00 p.m., CNS-A stated R4 had not been gone from the facility for any time during the months of June, July, or August. CNS-A stated they had set up R4's scheduled morning medications for every day. CNS-A stated they did not know why their documentation did not include all of the dates they set up. CNS-A stated they might have documented the first week box and forgotten to document the second week box but agreed that the documentation gaps were not consistent with that possibility.	01770		

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01770	Continued From page 46 The licensee's Medication Documentation policy, dated July 28, 2021, indicated documentation of medication set up would include: -date medication setup was completed; - name of each medication; - quantity of dose; - times to be administered; - route of administration; and - name and title of person completing medication setup. In addition, documentation of medication set up would be completed promptly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every twelve months for three of three residents (R2, R3, and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01830		

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01830	Continued From page 47 or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee and began receiving assisted living services on July 14, 2023. R2's diagnoses included limbic encephalitis, epilepsy, myoclonus, affective psychosis, and hyponatremia. R2's Service Plan- Addendum to Contract, dated July 17, 2023, indicated R2 received medication administration, assistance with dressing, grooming, bathing reminder, incontinence care, housekeeping, laundry, behavior management, shopping, transportation, and meal assistance. R2's Physician Orders dated August 11, 2023, indicated the following orders for R2: - aspirin 81 milligrams (mg) one tablet by mouth twice daily; - clonazepam 0.5 mg one and one-half tablets totaling 0.75 mg by mouth twice daily; - divalproex 500 mg three tablets totaling 1500 mg by mouth at bedtime; - divalproex 250 mg five tablets totaling 1250 mg by mouth daily; - docusate sodium 100 mg one capsule by mouth twice daily; - enulose 10 mg per 15 milliliter (ml) solution 15 ml by mouth twice daily; - fluoxetine 40 mg one capsule by mouth daily; - lacosamide 150 mg one tablet by mouth twice daily; - lamotrigine 100 mg one tablet by mouth twice daily;	01830		

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01830	Continued From page 48 - levocarnitine 330 mg one tablet by mouth three times daily; - loratadine 10 mg by mouth daily; - quetiapine 200 mg one tablet by mouth at bedtime; - quetiapine 50 mg one tablet by mouth twice daily; - acetaminophen 500 mg one to two tablets by mouth every six hours as needed; - lorazepam 2 mg/ ml inject one ml intramuscularly as needed for seizures; and - polyethlene glycol 17 grams (gm) one 17 gm packet dissolved in 240 ml of beverage by mouth twice daily as needed for constipation. R2's record lacked renewal of the above orders on or before August 11, 2024. On August 29, 2024, at 12:54 p.m., clinical nurse supervisor (CNS)-A stated they were aware R2's orders were due to be renewed. CNS-A stated R2 had recently had many order changes and they were waiting until R2's medical needs were more stable again to renew the annual orders. CNS-A stated they had been following directives from appointment after visit summaries even though they were not always signed. R3 R3 was admitted to the licensee and began receiving assisted living services on September 16, 2022. R3's diagnoses included fetal alcohol syndrome, impulse control disorder, persistent mood disorder, mild intellectual disability, attention deficit disorder, post-traumatic stress disorder, and Type 2 Diabetes. R3's Service Plan- Addendum to Contract, dated	01830		

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01830	Continued From page 49 October 17, 2022, indicated R3 received medication administration, blood glucose monitoring, assistance with dressing, grooming, incontinence care, bathing reminders, housekeeping, laundry, behavior management, safety checks, and shopping. R3's Physician Standing Orders dated September 20, 2022, indicated the following orders for R3: - obtain a urinalysis for increased incontinence, urinary frequency, altered mental status, confusion, delirium, sudden onset of weakness, falls without medical reason, and burning with urination; - cold packs as needed for sprains, bumps, contusions; - influenza vaccine if not allergic to eggs as needed at resident request; - over the counter (OTC) antacid by mouth every four hours as needed for heartburn or epigastric distress; - acetaminophen 650 mg tablet or suppository every four hours as needed for temperature over 99.9 degrees or pain; - OTC cough drops, Robitussin or Tussex by mouth every four hours as needed for cough according to label directions; - OTC antidiarrheal medication by mouth after each loose stool as needed and may use Imodium according to label directions, notify physician if diarrhea persists for longer than 48 hours; - OTC laxative by mouth or rectal suppository every day as needed for constipation and may use Milk of Magnesia or glycerin· suppository according to label directions; - antibiotic ointment and dressing to minor cuts and scrapes; and - transparent dressing to skin tears or abrasions.	01830		

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01830	Continued From page 50 R3's record lacked renewal of above standing orders on or before September 20, 2023. On August 29, 2024, at 12:54 p.m., CNS-A reviewed R3's record and acknowledged the most recent standing orders were obtained on September 20, 2022. CNS-A stated they must have missed sending the standing orders last time they renewed the other orders but did not recall why. CNS-A stated R3 should have standing orders in place as they frequently ask for acetaminophen for minor aches. R4 R4 was admitted to the licensee and began receiving assisted living services on May 29, 2023. R4's diagnoses included depression, hypertension, acid reflux. R4's Service Plan- Addendum to Contract, dated May 29, 2023, indicated R4 received medication set up, medication reminders, assistance with dressing, grooming, bathing reminders, housekeeping, laundry, and behavior management. R4's Physician Orders dated June 12, 2023, indicated the following orders for R4: - amlodipine besylate 5 mg one tablet by mouth daily; - bupropion extra-long (XL) release 300 mg one tablet by mouth daily; - cetirizine 10 mg one tablet by mouth daily; - metoprolol succinate extended release (ER) 50 mg one tablet by mouth daily; and - omeprazole 20 mg one capsule by mouth daily. R4's record lacked renewal of the above orders	01830		

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01830	Continued From page 51 on or before June 12, 2024. R4's Physician Standing Orders dated June 12, 2023, indicated the following orders for R4: - obtain a urinalysis for increased incontinence, urinary frequency, altered mental status, confusion, delirium, sudden onset of weakness, falls without medical reason, and burning with urination; - cold packs as needed for sprains, bumps, contusions; - influenza vaccine if not allergic to eggs as needed at resident request; - over the counter (OTC) antacid by mouth every four hours as needed for heartburn or epigastric distress; - acetaminophen 650 mg tablet or suppository every four hours as needed for temperature over 99.9 degrees or pain; - OTC cough drops, Robitussin or Tussex by mouth every four hours as needed for cough according to label directions; - OTC antidiarrheal medication by mouth after each loose stool as needed and may use Imodium according to label directions, notify physician if diarrhea persists for longer than 48 hours; - OTC laxative by mouth or rectal suppository every day as needed for constipation and may use Milk of Magnesia or glycerin· suppository according to label directions; - antibiotic ointment and dressing to minor cuts and scrapes; and - transparent dressing to skin tears or abrasions. R4's record lacked renewal of the above standing orders on or before June 12, 2024. On August 29, 2024, at 12:54 p.m., CNS-A reviewed R4's record and confirmed the most	01830		

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WELLNESS GROUP HOME CORPORATIO	2606 64TH AVENUE NORTH BROOKLYN CENTER, MN 55430

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01830	Continued From page 52 recent signed physician orders were dated June 12, 2023. CNS-A stated R4 had recently changed physicians and health care systems. CNS-A stated R4 had requested they not communicate with the previous health care system about anything. CNS-A stated that request had impacted obtaining new orders. CNS-A stated they had faxed a request for new orders to R4's new physician but had not received a response. CNS-A stated they had not called or followed up with the physician office about the orders yet. On August 29, 2024, at 12:54 p.m., clinical nurse supervisor (CNS)-A stated they were aware orders were required to be renewed at least every twelve months. CNS-A stated they received an alert in the electronic medical record when resident orders were due for renewal. CNS-A prepared the orders and faxed them to the resident's physician. CNS-A stated they did not have a tracking system for getting signed orders back and when additional follow up would be needed with the physicians. The licensee's Prescriber's Orders policy, dated July 28, 2021, indicated written orders from an authorized prescriber would be obtained for all medications with which the assisted living facility assisted residents, including over the counter medications. All medication orders would include the name of the medication, dosage, and directions for use. The registered nurse was responsible for implementing medication orders. Medication orders would be renewed at least every year or when changes occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36257	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLNESS GROUP HOME CORPORATIO	2606 64TH AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01830	Continued From page 53 days	01830		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *08/27/24*
Time: 13:27:14
Report: 7963241099

Food and Beverage Establishment Inspection Report

Location:
Wellness Group Home Corporatio
2606 64th Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038112
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634326699
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Quaternary Ammonia: = 150PPM at Degrees Fahrenheit
Location: SANI SPRAY
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 34 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: HOT DOGS
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

MET WITH MDH NURSE SURVEYOR PEGGY ANDERSON AND FACILITY REPRESENTATIVE ABDIRASHID ARAB.

DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-RESTRICTIONS REGARDING HIGHLY SUSCEPTIBLE POPULATIONS

-SAME DAY FOOD SERVICE
-VOMIT AND FECAL CLEAN UP
-SANITIZING DISHES AND UTENSILS

THIS IS A RESIDENTIAL HOUSE DOING SAME-DAY FOODSERVICE.

THEY USE A DISHWASHER WITH A SANITIZER CYCLE FOR WASHING AND SANITIZING DISHES AND UTENSILS.

KITCHEN HAS A CERAMIC FLOOR, WOOD CABINETS, LAMINATE COUNTERTOP AND POPCORN FINISH CEILING.

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 7963241099 of 08/27/24.

Certified Food Protection Manager: Abdirashid Arab

Certification Number: FM 87242 Expires: 08/26/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Abdirashid Arab
PIC

Signed: Peggy Spadafore

Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963241099

Food Establishment Inspection Report

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	0	Date	08/27/24
No. of Repeat RF/PHI Categories Out	0	Time In	13:27:14
Legal Authority MN Rules Chapter 4626		Time Out	

Wellness Group Home Corporatio	Address: 2606 64th Avenue North	City/State: Brooklyn Center, MN	Zip Code: 55430	Telephone: 7634326699
License/Permit #: 0038112	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		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:** 08/27/24

Inspector (Signature) Peggy Spurley