Electronically Delivered

May 18, 2023

Licensee
Meadow Woods Assisted Living
1301 East 100th Street
Bloomington, MN 55425

RE: Project Number(s) SL20264015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

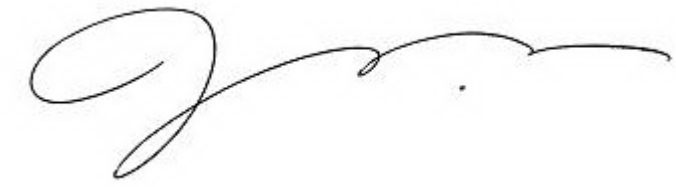
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20264	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW WOODS ASSISTED LIVING	1301 EAST 100TH STREET BLOOMINGTON, MN 55425

(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: SL#20264015 On May 1, 2023, through May 3, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 106 active residents; 103 receiving services under the Assisted Living/Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
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	0 680		

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0 680	Continued From page 1 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. (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 develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 1, 2023, at approximately 11:45 a.m.,	0 680		

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0 680	Continued From page 2 licensed assisted living director (LALD)-A provided a binder and indicated the contents were the licensee's EP plan. The licensee's EP plan undated, lacked: -documentation of annual review; and -documentation of missing resident quarterly review. On May 1, 2023, at approximately 12:50 p.m., LALD-A acknowledged the licensee's EP plan lacked the above listed required content, and was not aware of the required content of Appendix Z. The licensee's Missing Resident/Elopement policy dated August 1, 2021, indicated the licensee would review the missing resident plan at least quarterly and document any changes to the plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 3 Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On May 3, 2023, at approximately 10:00 a.m., survey staff toured the facility with the License Assisted Living Director (LALD)- A and Director of Environmental Services (DES)- H. During the facility tour, survey staff observed the following items: In the main dining room on the first floor, it was observed that the women's restroom door had been disabled by removing the closure arm or closure device. The door observed still had a portion or remnants of the closure device still mounted on the door. In the whirlpool room on the third floor, it was also observed that the exhaust fan did not work when it was tested. During the interview, DES-H stated that he was aware of the deficient condition and that the new part had been ordered. It was also	0 800		

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0 800	Continued From page 4 observed that the whirlpool room door had been disabled by removing the closure arm or closure device. The door observed still had a portion or remnants of the closure device still mounted on the door. The door was left open with a kick-down doorstop. It was observed that the egress door from the lower-level corridor to the vestibule could not be opened easily and stuck badly to the frame. This door was identified as an exit by an overhead exit sign. It was also observed that the exterior egress door from the vestibule on the lower level did not close and stayed open due to rust on the closure arm and closure device. DES-H visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640		

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01640	Continued From page 5 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or the resident's representative to document agreement on the services to be provided for three of six residents (R3, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 was admitted on May 24, 2021. R3's Service Plan Agreement signed May 3, 2022, was identified by clinical nurse supervisor (CNS)-B as R3's most current authenticated service plan. R3's Service Plan Agreement dated March 2, 2023, was provided by CNS-B, and indicated as R3's current service plan with services R3 was	01640		

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01640	Continued From page 6	01640		

receiving. The service plan included 61 identified services which were revised after the signed service plan dated May 3, 2022.

R5 was admitted on April 1, 2021.

R5's Service Plan Agreement signed February 1, 2023, was identified by CNS-B as R5's most current authenticated service plan.

R5's Service Plan Agreement dated March 2, 2023, was provided by CNS-B, and indicated as R5's current service plan with services R5 was receiving. The service plan included four identified services which were revised after the signed service plan dated February 1, 2023.

R6 was admitted on September 23, 2020.

R6's Service Plan Agreement signed February 2, 2023, was identified by CNS-B as R6's most current authenticated service plan.

R6's Service Plan Agreement dated March 2, 2023, was provided by CNS-B, and indicated as R6's current service plan with services R6 was receiving. The service plan included six identified services which were revised after the signed service plan dated February 2, 2023.

On May 2, 2023, at approximately 1:15 p.m., CNS-B indicated the licensee's expectation is all current service plans are signed by the RN who completed the document and then the resident or the resident's designated representative. CNS-B indicated licensee had completed R3's, R5's, and R6's service plan but was unsure why licensee did not sign or obtain the resident's authentication after revisions.

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01640	Continued From page 7 The licensee's Service Plan Agreement Development and Revision policy dated August 1, 2021, indicated any changes to the resident's service plan or agreement must be signed by the resident or the resident's representative and the licensee's representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained including the opened date for time sensitive medications for one of six residents (R5). 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).	01890		

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01890	Continued From page 8 The findings include: R5's service plan dated February 1, 2023, indicated R5 received services including assistance with safety checks, bathing, wound care, blood glucose testing, insulin, and medication administration. R5's medication administration record (MAR) for April 2023, indicated R5 received blood glucose testing four times daily, Novolog FlexPen (fast-acting insulin) 100 units (u) per milliliter (ml), four times daily, per sliding scale, and Lantus Solostar (long-acting insulin) 100 u/ ml, once daily. On May 2, 2023, at 7:55 a.m., the surveyor observed R5's medication storage of blood glucose testing supplies and opened insulin pens that were kept in the locked medication cart. R2's medication storage included one opened Novolog pen and one opened Lantus insulin pen. The insulin pens were opened and lacked labels to indicate the date staff first used the insulins and when the insulins should be discarded. R5's Novolog and Lantus insulin instructions on the MAR for April 2023, indicated the licensee would "Date vial/pen when taken out of refrigerator." On May 2, 2023, at 7:55 a.m., unlicensed personnel (ULP)-G acknowledged that the insulin pens for R5 had not been dated when first opened. ULP-G stated their process is to date insulin when it is first opened. On May 2,2023, at 8:01 a.m., registered nurse (RN)-F stated insulin pens should be dated when opened and first used. RN-F indicated that she	01890		

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01890	Continued From page 9	01890		

was unsure why this was missed. RN-F indicated that additional, unopened insulin supply for R5 were stored in the medication refrigerator in the nurses' office on second floor.

On May 2, 2023, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated that insulin pens should be dated when first opened. CNS-B indicated that R5 received all medication from an outside provider that did not send out the insulin pens with a label to mark the date opened when first used. CNS-B stated that the other residents used the licensee's contracted pharmacy, and these insulin pens came with a label to mark when insulin was first opened. CNS-B shared this may be why R5's insulin pen was not dated.

The manufacturer's instructions for the use of the Novolog dated June 2022, directed for the insulin to be stored at room temperature and to be discarded 28 days after being opened.

The manufacturer's instructions for the use of the Lantus dated June 2022, directed for the insulin to be stored at room temperature and discarded 28 days after being opened.

The Licensee's policy titled Storage of Medication and Key Security, dated April 19, 2023, included "Refrigeration of Biological Medications. Client medications needing to be refrigerated will be stored in the refrigerator in the client's apartment unless central storage is required. The nurse will determine if medications kept in the client's refrigerator need to be in a locked container. Also, medications requiring "refrigeration" or "temperatures between 2ºC [Celsius] (36ºF [Fahrenheit]) and 8ºC (46ºF)" are kept in a refrigerator with a thermometer to allow temperature monitoring daily; twice daily if

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01890	Continued From page 10 vaccines are being stored. Medications requiring storage "in a cool place" are refrigerated unless otherwise directed on the label. Controlled-substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator. If the temperature goes out of the noted temperature range, the nurse will review each medication and notify the manufacturer to review if the medication needs to be discarded." The Licensee's policy titled Medication Administration: Insulin Injection, dated August 1, 2021, lacked information on medication storage of insulin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	02040		

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02040	Continued From page 11 by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of the available documentation and an interview were conducted on May 3, 2023, at approximately 10:00 a.m. with the License Assisted Living Director (LALD)- A and Director of Environmental Services (DES)- H on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had a disaster plan with identified hazards, but not performed a hazard vulnerability assessment or safety risk assessment on and around the property, nor prescribed any mitigation factors for any of the hazards associated with the physical environment. During the interview, DES-H stated that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property.	02040		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW WOODS ASSISTED LIVING	1301 EAST 100TH STREET BLOOMINGTON, MN 55425

(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
02040	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *05/01/23*
Time: 12:23:46
Report: 7994231100

Food and Beverage Establishment Inspection Report

Location:
Meadow Woods Assisted Living
1301 East 100th Street
Bloomington, MN55425
Hennepin County, 27

Establishment Info:
ID #: 0037862
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528881010
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.

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

TEMPERATURES

TOMATOES 38
COLE SLAW 39 (COOLED)
PEAS 43 (COOLING)
RIBS 148
HOT DOGS 163
SOUP 149

SANITIZERS
DISHWASHER 169 F
3 COMP SINK 200 PPM QUAT

Type: Full
Date: *05/01/23*
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Meadow Woods Assisted Living

Food and Beverage Establishment Inspection Report

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 7994231100 of 05/01/23.

Certified Food Protection Manager: Radjwatie Awatar

Certification Number: 38689 Expires: 04/02/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994231100

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	0	**Date**	05/01/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:23:46
Legal Authority MN Rules Chapter 4626		**Time Out**	

Meadow Woods Assisted Living	**Address** 1301 East 100th Street	**City/State** Bloomington, MN	**Zip Code** 55425	**Telephone** 9528881010
License/Permit # 0037862	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/01/23

Inspector (Signature) Crystal Elva