



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

September 17, 2025

Licensee

Good Samaritan Society - St James  
1102 2nd Street South  
Saint James, MN 56081

RE: Project Number(s) SL30578016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

### **STATE CORRECTION ORDERS**

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

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

### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto: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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: [Jodi.Johnson@state.mn.us](mailto:Jodi.Johnson@state.mn.us)

Telephone: 507-344-2730 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>SL30578016-0</b></p> <p>On September 2, 2025, through September 4, 2025, 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 23 residents; 22 receiving services under the Assisted Living Facility license.</p>	0 000	<p>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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>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.</b></p>	
0 470 SS=C	<p><b>144G.41 Subdivision 1 Minimum requirements</b></p> <p><b>(11) develop and implement a staffing plan for</b></p>	0 470		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
--------------------	--	---------------	---	--------------------

0 470	<p>Continued From page 1</p> <p>determining its staffing level that:</p> <ul style="list-style-type: none"> <li>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</li> <li>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and</li> <li>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;</li> </ul> <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <ul style="list-style-type: none"> <li>(i) awake;</li> <li>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</li> <li>(iii) capable of communicating with residents;</li> <li>(iv) capable of providing or summoning the appropriate assistance; and</li> <li>(v) capable of following directions;</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the staff posting included all the required elements, potentially affecting all the licensee's current residents, staff, and visitors.</p> <p>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</p>	0 470		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
--------------------	--	---------------	---	--------------------

0 470	<p>Continued From page 2</p> <p>widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).</p> <p>The findings included:</p> <p>During the entrance conference on September 2, 2025, at 10:44 a.m., licensed assisted living director (LALD)-A stated the staffing shift hours were as follows: Day shift: One staff 6:30 a.m. - 2:30 p.m., and one staff from 6:30 a.m. - 3:00 p.m.; evening shift: One staff 2:30 p.m. - 11:00 p.m., and one staff 3:00 p.m. - 11:00 p.m.; night shift: One staff 11:30 p.m. - 8:00 a.m.</p> <p>During the tour on September 2, 2025, at 11:53 a.m., the surveyor observed the staff posting on a whiteboard near the dining room with LALD-A. The posting included included how many unlicensed staff were working for the day, evening, and night shift; the schedule did not indicate the specific times of each shift. LALD-A stated specific hours for each shift was not included on the posting and was not aware of the requirement.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 470		
0 480 SS=F	<p>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p>	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
0 480	<p>Continued From page 3</p> <p>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:</p> <p>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;</p> <p>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;</p> <p>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;</p> <p>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;</p> <p>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;</p> <p>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant</p>	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
--------------------	--	---------------	---	--------------------

0 480	<p>Continued From page 4</p> <p>lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 2, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
0 660	Continued From page 5	0 660		
0 660 SS=D	<p><b>144G.42 Subd. 9 Tuberculosis prevention and control</b></p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for two of three employees (ULP-E, ULP-F).</p> <p>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</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
0 660	<p>Continued From page 6</p> <p>a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>The licensee's TB facility risk assessment dated April 18, 2025, indicated the licensee was a low risk.</p> <p>ULP-E ULP-E was hired March 4, 2025, to provide direct care services.</p> <p>ULP-E's employee record included a TB symptom screen from a former employer dated January 5, 2022. The record further included 2-step TST testing from the same prior employer. The first step placed January 5, 2022, and read January 7, 2022; the second step placed January 18, 2022, and read January 20, 2022. The TB symptom screen and two-step TST testing was completed greater than three years prior to hire.</p> <p>ULP-F ULP-F was hired October 24, 2021, to provide direct care services.</p> <p>On September 3, 2025, at 7:43 a.m., the surveyor observed ULP-F applying Velcro compression wraps to R2's lower legs.</p> <p>ULP-F's employee record lacked documentation of a TB symptom screen and two-step TST or other evidence of TB screening.</p> <p>On September 3, 2025, at 10:03 a.m., licensed assisted living director (LALD)-A stated ULP-F's employee file lacked the above TB requirements. LALD-A reviewed ULP-E's TB symptom screen and TB testing from a previous employer upon</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
0 660	<p>Continued From page 7</p> <p>hire and stated it did not meet the requirements.</p> <p>The licensee's Tuberculosis Control Plan and Screening for Employees, Senior Living, Rehab/Skilled, Home Health, Child Day-Enterprise policy reviewed/revised December 7, 2023, indicated:</p> <ul style="list-style-type: none"> <li>- Prior to or upon hire, all employees will be screened for TB risk and for signs or symptoms of active TB disease: persistent cough (greater than three weeks duration), especially in the presence of other symptoms or signs compatible with TB, such as complaints of bloody sputum, night sweats, weight loss, anorexia or fever.</li> <li>- Prior to or upon hire, all employees will receive a baseline tuberculin skin test (TST) or single TB blood test.</li> </ul> <p>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record	0 730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
0 730	<p>Continued From page 8</p> <p>Contents of a resident record include the following for each resident:</p> <ul style="list-style-type: none"> <li>(1) identifying information, including the resident's name, date of birth, address, and telephone number;</li> <li>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;</li> <li>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;</li> <li>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;</li> <li>(5) the resident's advance directives, if any;</li> <li>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;</li> <li>(7) the facility's current and previous assessments and service plans;</li> <li>(8) all records of communications pertinent to the resident's services;</li> <li>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;</li> <li>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;</li> <li>(11) documentation that services have been provided as identified in the service plan;</li> <li>(12) documentation that the resident has received and reviewed the assisted living bill of rights;</li> <li>(13) documentation of complaints received and</li> </ul>	0 730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
0 730	<p>Continued From page 9</p> <p>any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3).</p> <p>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).</p> <p>The findings include:</p> <p>R6's record lacked a discharge summary to include: - diagnoses; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status.</p> <p>R3 was admitted to the licensee on February 10,</p>	0 730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
0 730	<p>Continued From page 10</p> <p>2025, with diagnoses including: dementia, parkinsonism (brain conditions that cause slowed movement, rigidity and tremors), and hypertension (high blood pressure). R3 discharged from the facility on August 16, 2025.</p> <p>On September 4, 2025, at 11:29 a.m., licensed assisted living director (LALD)-A stated R3's discharge summary would be in a progress note.</p> <p>On September 4, 2025, at 12:35 p.m., clinical nurse supervisor (CNS)-B reviewed the discharge summary criteria and stated R3's progress notes related to discharge lacked the required content.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days</p>	0 730		
01060 SS=F	<p>144G.52 Subd. 9 Emergency relocation</p> <p>(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.</p> <p>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <p>(1) the reason for the relocation;</p> <p>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;</p> <p>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
01060	<p>Continued From page 11</p> <p>(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</p> <p>(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.</p> <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <p>(1) the resident, legal representative, and designated representative;</p> <p>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and</p> <p>(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.</p> <p>(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</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R2) who was hospitalized.</p> <p>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</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
01060	<p>Continued From page 12</p> <p>the residents).</p> <p>The findings include:</p> <p>R2's diagnoses included type II diabetes mellitus with diabetic neuropathy and polycythemia vera (rare blood disorder).</p> <p>R2's Service Agreement dated December 19, 2024, indicated R2 received services including medication administration, assistance with bathing, dressing, daily weight, compression wraps, housekeeping, and laundry.</p> <p>R2's After Visit Summary dated March 3, 2025, indicated R2 had been hospitalized from February 28, 2025, until March 3, 2025, then returned to the licensee.</p> <p>R2's record lacked a written notice that contained, at a minimum:</p> <ul style="list-style-type: none"> <li>- the reason for the relocation;</li> <li>- the name and contact information for the location to which the resident has been relocated and any new service provider;</li> <li>- contact information for the Office of Ombudsman for Long-Term Care;</li> <li>- 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;</li> <li>- 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.</li> </ul> <p>In addition, R1's record lacked evidence of notification to OOLTC when they were hospitalized more than four days.</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
01060	Continued From page 13  On September 4, 2025, at 10:03 a.m., licensed assisted living director (LALD)-A, stated the licensee did not provide an emergency transfer notice to the resident, legal representative, and designated representative when any residents were hospitalized, although did provide the notice to the ombudsman if gone four days or more.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required  (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received an affiliation with the	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
--------------------	--	---------------	---	--------------------

01290	<p>Continued From page 14</p> <p>assisted living license for one of two employees (unlicensed personnel (ULP)-D).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-D was hired on November 18, 2015, to provide direct care and services to the licensee's residents.</p> <p>During the entrance conference on September 2, 2025, at 10:44 a.m., licensed assisted living director (LALD)-A provided the NETStudy 2.0 employee roster for health facility identification number (HFID) 30578 at the surveyor's request. ULP-D's background study dated December 20, 2021, was affiliated to HFID 30703, but indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 roster page. Further review of NETStudy 2.0 revealed ULP-D had a cleared background study dated May 11, 2022, for a separate location operated by the same corporation. ULP-D's employee record lacked evidence the licensee affiliated a background study for their license.</p> <p>On September 2, 2025, at 1:19 p.m., the surveyor requested a copy of ULP-D's background study from LALD-A. LALD-A stated she would need to request this from the corporate office. LALD-A</p>	01290		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30578</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - ST JAMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1102 2ND STREET SOUTH SAINT JAMES, MN 56081</b>
--	---

(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
01290	<p>Continued From page 15</p> <p>further stated ULP-D was a PRN (as needed) employee although still was active in providing unsupervised direct care to the licensee's residents. At 2:14 p.m., LALD-A provided the surveyor with ULP-D's background study dated September 2, 2025. LALD-A reviewed the date of the background study and stated it had been affiliated with the licensee on the same day as requested.</p> <p>The licensee's Hiring and Screening policy reviewed/revised March 28, 2025, indicated: Human Resources will conduct background checks on all new employees and transfers prior to beginning employment or transferring to a new position.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	01290		



Mankato District Office  
 Minnesota Department of Health  
 12 Civic Center Plaza, Suite 2105  
 Mankato, MN 56001  
 Phone: 651-201-4500

## Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
GOOD SAMARITAN SOCIETY ST JAMES 1102 2ND STREET SOUTH St James, MN 56081 Watonwan County Parcel:  Phone:	License: HFID 30578  Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F1033251160 Inspection Type: Full - Single Date: 9/2/2025 Time: 10:50 AM Duration: minutes Announced Inspection: No <u>Total Priority 1 Orders: 1</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 2</u> <u>Delivery: Emailed</u>

**! New Order: 5-200B Plumbing: cross connections**

5-203.14A      *Priority Level: Priority 1   CFP#: 51*

*MN Rule 4626.1085A* Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

COMMENT: Ice machine drain is stored in the floor drain.

*Comply By: 9/2/2025      Originally Issued On: 9/2/2025*

**New Order: 6-100 Physical Facility Construction Materials**

6-101.11A1      *Priority Level: Priority 3   CFP#: 55*

*MN Rule 4626.1325A1* Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

COMMENT: Floor tile damage and ceiling damage observed in the kitchen. Wall damage in the mop room around the mop sink.

*Comply By: 1/30/2026      Originally Issued On: 9/2/2025*

**New Order: 6-300 Physical Facility Numbers and Capacities**

6-301.14A      *Priority Level: Priority 3   CFP#: 10*

*MN Rule 4626.1457* Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: Hand wash reminder sign is missing from the restrooms.

*Comply By: 9/19/2025      Originally Issued On: 9/2/2025*

**NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

**I acknowledge receipt of the Mankato District Office inspection report number F1033251160 from 9/2/2025**

*Isaiah Armendariz*

\_\_\_\_\_  
 Establishment Representative

\_\_\_\_\_  
 Isaiah Armendariz,  
 Public Health Sanitarian 2  
 507-344-2743  
 isaiah.armendariz@state.mn.us

Mankato District Office  
Minnesota Department of Health  
12 Civic Center Plaza, Suite 2105  
Mankato, MN 56001

---

---

Temperature Observations/Recordings

Page: 1

Establishment Info

GOOD SAMARITAN SOCIETY ST JAMES  
St James  
County/Group: Watonwan County

Inspection Info

Report Number: F1033251160  
Inspection Type: Full  
Date: 9/2/2025  
Time: 10:50 AM

**Equipment Temperature: Product/Item/Unit: ; Temperature Process:** Ambient Air

**Location:** Upright Cooler at 34 Degrees F.

Comment:

*Violation Issued?: No*

**Equipment Temperature: Product/Item/Unit: ; Temperature Process:** Ambient Air

**Location:** Upright Freezer at 0> Degrees F.

Comment:

*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** Meatloaf; **Temperature Process:** Hot-Holding

**Location:** Steam Table at 166 Degrees F.

Comment:

*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** Mashed Potatoes; **Temperature Process:** Hot-Holding

**Location:** Steam Table at 170 Degrees F.

Comment:

*Violation Issued?: No*

---

---

Mankato District Office  
Minnesota Department of Health  
12 Civic Center Plaza, Suite 2105  
Mankato, MN 56001

---

---

Sanitizer Observations/Recordings

Page: 1

Establishment Info

GOOD SAMARITAN SOCIETY ST JAMES  
St James  
County/Group: Watonwan County

Inspection Info

Report Number: F1033251160  
Inspection Type: Full  
Date: 9/2/2025  
Time: 10:50 AM

**Sanitizing Equipment:** Product: Hot Water; **Sanitizing Process:** Dish Machine

**Location:** Dishwashing Area **Equal To** 166 Degrees F.

Comment:

*Violation Issued?: No*

# Food Establishment Inspection Report

<p><b>Mankato District Office</b> Minnesota Department of Health 12 Civic Center Plaza, Suite 2105 Mankato, MN 56001</p>	No. of Risk Factor/Intervention/Violations	1	Date: 9/2/2025
	No. of Repeat Risk Factor/Intervention/Violations		Time: 10:50 AM
	Score (optional)		Dur: min

Establishment: GOOD SAMARITAN SOCIETY ST JAMES	Address: 1102 2ND STREET SOUTH	City/State: St James, MN	Zip: 56081	Phone:
License/Permit #: HFID 30578	Permit Holder:	Purpose of Inspection: Full	Est. Type:	Risk Category:

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance    OUT=not in compliance    N/O=not observed    N/A=not applicable			Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection    R=repeat violation		
Compliance Status	COS	R	Compliance Status	COS	R
<b>Supervision</b>					
1	IN		18	N/O	
Person in charge present, demonstrate knowledge and performs duties			Proper cooking time & temperatures		
2	IN		19	N/O	
Certified Food Protection Manager			Proper reheating procedures for hot holding		
<b>Employee Health</b>					
3	IN		20	N/O	
knowledge, responsibilities, and reporting			Proper cooling time and temperature		
4	IN		21	IN	
Proper use of restriction and exclusion			Proper hot holding temperatures		
5	IN		22	IN	
Response to vomiting, diarrheal events			Proper cold holding temperatures		
<b>Good Hygienic Practices</b>					
6	N/O		23	IN	
Proper eating, tasting, drinking, tobacco use			Proper date marking & disposition		
7	IN		24	N/A	
No discharge from eyes, nose, and mouth			Time as public health control; procedures & record		
<b>Preventing Contamination by Hands</b>					
8	IN		<b>Consumer Advisory</b>		
Hands clean and properly washed			25    N/A    Consumer advisory provided for raw or undercooked foods		
9	IN		<b>Highly Susceptible Populations</b>		
No bare hand contact with RTE foods, alternatives			26    IN    Pasteurized foods used; prohibited foods not offered		
10	OUT		<b>Food/Color Additives and Toxic Substances</b>		
Adequate handwashing sinks supplied and access			27    N/A    Food additives; approved & properly used		
<b>Approved Source</b>					
11	IN		28    IN    Toxic substances properly identified; stored; used		
Food obtained from approved source			<b>Conformance with Approved Procedures</b>		
12	N/O		29    N/A    Compliance with variance, specialized processes & HACCP plan		
Food Received at proper temperature			<b>Risk factors</b> are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury		
13	IN				
Food in good condition, safe & unadulterated					
14	N/A				
Records available: shellstock tags, parasite dest.					
<b>Protection From Contamination</b>					
15	IN				
Food separated and protected					
16	IN				
Food-contact surfaces; cleaned & sanitized					
17	IN				
Proper Disposition of returned, previously served, reconditioned, & unsafe food					

## GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.					
Mark "X" or OUT in box if numbered item is <b>not</b> in compliance			Mark "X" in appropriate box for COS and/or R    COS=corrected on-site during inspection    R=repeat violation		
Compliance Status	COS	R	Compliance Status	COS	R
<b>Safe Food and Water</b>					
30	N/A		<b>Proper Use of Utensils</b>		
Pasteurized eggs used where required			43       In-use utensils; Properly stored		
31			44       Utensils, equipment & linens; properly stored, dried, handled		
Water & ice from approved source			45       Single-use & single-service articles, properly stored and used		
32	N/A		46       Gloves used properly		
Variance obtained for specialized processing methods			<b>Utensils, Equipment and Vending</b>		
<b>Food Temperature Control</b>					
33			47       Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
Proper cooling methods used; adequate equipment for temperature control			48       Warewashing facilities: installed, maintained, used; test strips		
34	N/O		49       Non-food contact surfaces clean		
Plant food properly cooked for hot holding			<b>Physical Facilities</b>		
35	N/O		50       Hot & cold water available; adequate pressure		
Approved thawing methods used			51    X    Plumbing installed; proper backflow devices		
36			52       Sewage & waste water properly disposed		
Thermometers provided & accurate			53       Toilet facilities; properly constructed, supplied & cleaned		
<b>Food Identification</b>					
37			54       Garbage & refuse properly disposed; facilities maintained		
Food properly labeled; original container			55    X    Physical facilities installed, maintained & clean		
<b>Prevention of Food Contamination</b>					
38			56       Adequate ventilation & lighting; designated areas used		
Insects, rodents, & animals not present; no unauthorized person			57       Compliance with MCIAA		
39			58       Compliance with licensing and plan review		
Contamination prevented during food prep, storage, & display					
40					
Personal cleanliness					
41					
Wiping cloths: properly used & stored					
42					
Washing fruits & vegetables					

Person in Charge (signature) \_\_\_\_\_

Inspector (signature) *Isaiak Armendariz*

Follow-up: \_\_\_\_\_ Follow-up Date: \_\_\_\_\_