Electronically Delivered

August 27, 2025

Licensee
Duale Inc
1167 15th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL37655016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 10, 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 . . ."

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

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

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addtion to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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: SL37655016-0 On July 8, 2025, through July 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following orders are issued. At the time of the survey, there was one resident; one resident receiving services under the Assisted Living Facility license.	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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the licensed assisted living director was listed as the Director of Record (DOR) for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/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 the potential to affect a large portion or all the residents). The findings include: Licensed assisted living director (LALD)-A started employment on January 26, 2024, and began providing assisted living services. On July 8, 2025, at 8:31 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A held a current assisted living director license however was not listed as the licensee's DOR. On July 8, 2025, at 10:19 a.m., BELTSS director of assisted living and education stated via email a	0 110		

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0 110	Continued From page 2 DOR was not listed for the licensee. On July 8, 2025, at 12:00 p.m., during the entrance conference, LALD-A was identified as the primary LALD for the facility. On July 8, 2025, at 1:00 p.m., during a tour of the facility, the surveyor observed LALD-A's assisted living director license, expiration date October 31, 2025, posted on the wall. On July 10, 2025, at 4:15 p.m., LALD-A explained when they took the position of the licensee's LALD, they assumed they would also become the DOR of the facility. LALD-A stated the licensee would ensure they were now listed as the DOR for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (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	0 480		

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0 480	Continued From page 3 supervise each facility's food service operation; (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; (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; (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; (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; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant 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.	0 480		

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0 480	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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	0 680		

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0 680	Continued From page 5 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 have a written emergency preparedness plan (EPP) with all the required content. In addition, the licensee failed to ensure the missing resident policy was reviewed quarterly as required under section 4659.0110. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 680		

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0 680	Continued From page 6 The findings include: The licensee's EP plan, dated July 2021, lacked the following required content: -consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies -categorize the various probable risks/hazards by likelihood of occurrence -develop strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans). -consider duration of interruptions. -procedures for tracking of staff and residents. -include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response. - policies and procedures (P/P) for, at minimum: - food, water, and pharmaceutical supplies - alternate sources of energy - sewage/waste disposal. - address using volunteers - 1135 waiver - tracking of staff and residents On July 10, 2025, at 4:15 p.m., licensed assisted living director (LALD)-A stated although the licensee did revise the EPP since the last survey, there were still some components missing. LALD-A stated going forward the licensee would meet on a regular basis to ensure the EPP stayed current and up to date and met the protocol to ensure he safety of residents and staff on the facility. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would identify and have in place a plan to assure	0 680		

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0 680	Continued From page 7 the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some 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). The findings include: On July 9, 2025, from approximately 12:36 p.m. to 2:35 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following	0 775		

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0 775	Continued From page 8 deficient conditions: A panel labelled "automatic fire alarm" was supplied in the front stairwell but was not functional. LALD-A confirmed that the panel was a remnant of the building and was not operational. Any devices present that give the appearance of fire safety equipment should be maintained in working order or removed if allowable. A multiplug adapter was in use in resident room 3. The supplied multiplug adapter was not rated for continuous use and may pose a fire risk. LALD-A acknowledged the use of the multiplug adapters and indicated that they would conduct further training with residents to avoid use of such devices. Multiple extension cords were in use in the living room on the lower level to power appliances and equipment. Extension cords are not intended for permanent use and should not be used in lieu of permanent wiring as it may pose a fire hazard. The egress window in resident room 4 was painted over and difficult to open, requiring significant effort to operate. The resident room was not occupied during time of inspection, but resident room windows were identified as egress component in facility evacuation plans and should be maintained in proper working condition and easily openable. Chain locks were supplied on doors in the kitchen and living room. The chain locks were supplied at 58 inches from the floor, a height above the allowable maximum to be safe. Chain locks were not readily operable when attempted during inspection to lock the doors but should be	0 775		

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0 775	Continued From page 9 removed to prevent limiting egress in the case they can be made operable. During the facility tour interview on July 9, 2025, LALD-A verified the above-listed fire protection and physical environment observations while accompanying on the tour. The surveyor explained to LALD-A the requirements for the fire safety orders mentioned above. LALD-A acknowledged the conditions and stated they understood requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780		

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0 780	Continued From page 10 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 9, 2025, from approximately 12:36 p.m. to 2:35 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following deficient conditions: When tested, smoke alarms provided in the main floor living room, front stairwell, and basement were not interconnected such that activation of one alarm activates all alarms. Smoke alarms were tested. Smoke alarms must be interconnected so activation of one alarm activates all alarms within the facility.	0 780		

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0 780	Continued From page 11 The provided smoke alarm in the front stairwell was chirping to indicate a low battery condition. Smoke alarms should be maintained in fully functional manner, with proper power supply to ensure functionality during an emergency. Several mounting plates were supplied throughout the facility that were not equipped with corresponding smoke alarms. Excess smoke alarm plates should be maintained with corresponding smoke alarms, or removed if not required. Battery operated smoke alarms were provided throughout the facility on hardwired smoke alarm mounts. The power supply of hardwired smoke alarms must be maintained, and hardwired smoke alarms on hardwired mounts must be supplied and maintained. During the facility tour interview on July 9, 2025, LALD-A verified the above-listed fire protection and physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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	37655	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

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0 800	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 July 9, 2025, from approximately 12:36 p.m. to 2:35 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following deficient conditions: The bathroom floor in the upper-level restroom was bowed in and had evidence of water damage. The floor was noticeably soft when walked on, especially around the toilet. The floor should be maintained in safe and stable condition, free of water damage. The ground fault circuit interrupter (GFCI) outlet in the upper-level restroom would not trip when tested. The GFCI should be maintained in proper working order to mitigate risk of electrical shock	0 800		

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0 800	Continued From page 13 from the outlet. The ground fault circuit interrupter (GFCI) outlet in the lower-level restroom would not trip when tested. The GFCI should be maintained in proper working order to mitigate risk of electrical shock from the outlet. The lower-level bathroom sink was supplied with improper plumbing fixtures. Flexible plastic piping was in use and no p-trap or similar method to prevent gases from escaping from plumbing was implemented at the sink. There was a noticeable odor from the sink. Plumbing must be done and maintained in proper condition using approved methods and equipment. The flooring on the lower-level bathroom was dirty and tiles were cracked, missing or peeling up. The floor should be maintained in sanitary and waterproof condition. The rear stairwell was not maintained in safe condition. The walls of the stairwell had holes and gaps that would permit weather or pests to gain entry, especially near the base. The walls and floors in the rear stairwell were significantly dirty and were covered in dust, leaves, and dirt. Exposed nails were also present in the walls, which could snag or scratch someone utilizing the stairwell. The electrical outlets in the stairwell appeared damaged and painted over and there were broken junction boxes with wiring exposed. The foundation in the rear stairwell was spalling, crumbling and/or damaged exposing holes to the exterior. There was water present in the rear stairwell on and near the stored chair, which may indicate leak. LALD-A stated the rear staircase is not frequently used and expressed that they were hesitant to follow the surveyor into the stairwell	0 800		

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0 800	Continued From page 14 due to its condition. The facility stairwell should be maintained in safe and sanitary condition. The rear door assembly was significantly damaged with large gaps around the frame, specially along the bottom of the frame that would permit weather and pests. The door was damaged and not maintained in proper working order. The air conditioning vents throughout the facility were clogged with dirt and dust and not maintained in clean state. The vent in resident room 4 was almost completely painted over and would not function to deliver air to resident room 4 and may be accumulating buildup behind the painted vent. Vents should be maintained in clean and sanitary manner. LALD-A acknowledged the buildup, stating the building was purchased in that condition and the vents had not been cleaned since. LALD-A indicated the vents would be cleaned. Window screens were damaged or missing on several windows throughout the facility. Window screens should be maintained in proper condition. Siding on the facility was damaged or missing in several sections. Siding should be maintained in proper condition. Paint around the exterior of the facility was peeling and chipping significantly. The paint around the windows and on door frames, soffit and fascia was largely chipped off and missing. Exterior elements of the property should be maintained with paint or protective covering to prevent decay, rot or damage. The front door to the facility was damaged, with wood boards coming loose and hanging on the	0 800		

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0 800	Continued From page 15 bottom of the door. The door had evidence of rotting and chipped wood in some locations. The door should be maintained in proper condition. The exterior window frames around the property had holes, cracks and decay. Window frames should be maintained in proper condition. The foundation of the property had large cracks and spalling around all sides of the property. The garage had damage to the trim, with pieces hanging loose and damaged wood. The supplied fence had many significantly warped, missing and damaged boards with some exposed screws. Supplied fences should be maintained in proper condition. During the facility tour interview on July 9, 2025, LALD-A verified the above listed physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 16 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 810		

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0 810	Continued From page 17 the residents). The findings include: On July 9, 2025, at approximately 2:00 p.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to include location and number of resident rooms. Facility diagrams for the upper-level were provided on the walls of the facility, but no diagrams were available in the FSEP and plans for the lower-level were hand drawn and inaccurate. The FSEP should include information about the location and number of resident rooms. The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to identify specific fire protection actions for employees. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that employees should follow in case of a fire or similar emergency. Documents regarding general fire prevention were provided with general information but FSEP did not have site specific information. Multiple documents were submitted to the surveyor, but no plan with employee actions was presented or available in the FSEP binder.	0 810		

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0 810	Continued From page 18 Record review indicated the licensee failed to provide training to residents at least once per year on the FSEP. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. LALD-A stated residents received educare training, but such training was not specific to procedures to evacuate the facility or the FSEP. Residents who are capable of assisting in their evacuation should be provided training at least once a year. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. LALD-A stated the educare training was implemented but not indicate any site-specific fire safety information was provided. No documentation of employee training on the FSEP was provided. Employees should be provided training upon hire and at least twice a year thereafter. Record review indicated that identification of unique resident needs for evacuation was not developed. No documentation was provided to the surveyor in the FSEP outlining unique or unusual resident needs for evacuation. LALD-A added indication of resident needs for evacuation to documents during the record review, but upon discussion had to change indicated evacuation level as it had been misidentified. A proper assessment and determination of resident needs for evacuation should be done and both provided and maintained accurate. The FSEP should include procedures for resident movement or evacuation including identifying their unique or unusual needs for movement or evacuation.	0 810		

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0 810	Continued From page 19 Fire drill records were provided to the survey indicating that drills occurred on 6/16/25, 11/24/24, 6/18/24, and 11/5/23. Provided evacuation drills were not sufficient. Evacuation drills should be occurring at least twice per year per shift and at least once every other month. During an interview on July 9, 2025, the surveyor explained the requirements for employee trainings, resident trainings, FSEP documentation, and evacuation drills. LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	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 licensee's liability for health, safety, or personal property for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 970		

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0 970	Continued From page 20 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: R1 was admitted to the facility on September 27, 2023, and had diagnoses including coronary artery disease, chronic obstructive pulmonary disease and congestive heart failure. R1's Service Plan Agreement dated, April 2, 2024, indicated R1 received services including assistance with activities of daily living (ADLs), medication management, laundry, and set-up assistance with meals. R1's Assisted Living Contract signed November 9, 2023, included the following language indicating waivers of liability: -Indemnification: "The licensee shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold Duale Inc harmless from any claims or damages unless caused solely by negligence of Duale Inc. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident. " On July 10, 2025, at 4:15 p.m., licensed assisted living director (LALD)-A stated they were not aware the waiver was in resident contracts LALD-A explained the licensee perceived the	0 970		

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0 970	Continued From page 21 contract was adequate after changes made with the last survey results. LALD-A stated the same contract was used for all residedents past and present. LALD-A stated the licensee would make all necessary corrections for the current resident (R1) and future residents admitted to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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	01060		

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01060	Continued From page 22 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. (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 the required content to the resident, legal representative, and designated representative in the event of an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's Service Plan Agreement dated, April 2, 2024, indicated R1 received services including	01060		

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01060	Continued From page 23 assistance with activities of daily living (ADLs), medication management, housekeeping, laundry, and meals. The licensee's Nurse Reassessment Visit Form, dated June 4, 2025, indicated R1 was hospitalized on the following dates: -June 2, 2025, through June 4, 2025, related to hematuria (the presence of blood in the urine), difficulty urinating and acute cystitis (an inflammation of the bladder, often caused by a bacterial infection) -February 9, 2025, through February 12, 2025, related to acute cystitis with hematuria -February 15.2025 through February 17, 2025, related to hematuria R1's record lacked evidence a written notice was provided to the resident, legal representative, and designated representative, that contained: -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 the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); -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. On July 8, 2025, at 10:35 a.m. the clinical nurse supervisor (CNS)-B, stated R1 had been admitted	01060		

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01060	Continued From page 24 to the hospital June 2, 2025, through June 4, 2025. CNS-B stated they were not aware if the emergency relocation process was completed upon admission to the hospital because they were not working at that time. On July 10, 2025, at 4:15 p.m., LALD-A stated nursing was responsible to complete the required steps for an emergency relocation. LALD-A stated the licensee did not provide an emergency relocation notification to R1 or their representative on any of the above-mentioned hospital admissions. LALD-A stated they were not aware of this requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Duale Inc
1167 15th Ave SE
Minneapolis, MN 55414
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36113

Risk:
License:
Expires on:
CFPM: ISTAHIL ABDI
CFPM #: 120127; Exp: 10/23/2026

Inspection Info

Report Number: F1029251061
Inspection Type: Full - Single
Date: 7/9/2025 Time: 1:01:01 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 3
Total Priority 3 Orders: 6
Delivery:

! **New Order: 3-100 Food Characteristics: unadulterated**
3-101.11 *Priority Level: Priority 1 CFP#: 13*
MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.
COMMENT: OLD POTATO WITH SPROUTS GROWING OUT OF IT. OPERATOR DISCARDED. ENSURE OLD GREEN SPROUTED POTATOES ARE REMOVED FROM SERVICE DUE TO POSSIBLE SOLANINE POISON FORMATION.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: WIPING CLOTH NOT HELD IN SANITIZER SOLUTION. CORRECTED DURING INSPECTION.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-307.11 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.
COMMENT: PIPES WITH PEELING AND CHIPPING PAINT ABOVE PLATES AND OTHER FOOD HOLDING VESSELS IN CABINET RIGHT OF SINK, AND PAINT PEELING AND CHIPPING IN LARGE DRY STORAGE SHELVING AREA. OPERATOR INSTRUCTED TO TAKE STEPS TO HAVE THE AREAS REPAIRED OR REPLACED TO ENSURE FOOD IS NOT CONTAMINATED WITH FOREIGN MATERIALS.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

New Order: 3-500C Microbial Control: date marking
3-501.17A *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.
COMMENT: CHOPPED CABBAGE WITHOUT DATE MARKINGS. CABBAGE PREP DATE KNOWN TO BE 7 DAYS AGO USING PREP DATE AS DAY 1. OPERATOR INSTRUCTED TO DISCARD AFTER THE 7TH DAY AND TO DATE MARK REQUIRED ITEMS.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: BAGGED LETTUCE MIX SHOWING SIGNS OF SPOILAGE WITH MANUFACTURER USE BY DATE OF JUNE 28, 2025. DISCARDED BY OPERATOR. OPENED CAN OF SPAM IN PLASTIC BAG. DATE OF OPENING KNOWN TO BE WITHIN THE 7-DAY USE WINDOW. OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS, LIKE OPENED DELI MEATS.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

New Order: 4-100 Equipment Construction Materials
4-101.19 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.
COMMENT: FINISHES ON FLOORS, WALLS, AND CEILING AND CABINETRY AND DRAWERS IN DISREPAIR. MAINTAIN SANITARY AND PEST FREE. IF THE ESTABLISHMENT IS UNABLE TO MAINTAIN SANITARY PEST FREE CONDITIONS THE FINISHES MUST BE BROUGHT INTO A STANDARD TO ENABLE SANITARY PEST FREE CONDITIONS.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C1 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.
COMMENT: CHLORINE SOLUTION IN WIPING CLOTH BUCKET AND SPRAY BOTTLE AT TOO LOW OF A CONCENTRATION TO SANITIZE. CORRECTED DURING INSPECTION TO EFFECTIVE SANITIZING CONCENTRATIONS.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.12 *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.
COMMENT: SPLATTERING IN MICROWAVE. CLEAN AND MAINTAIN CLEAN.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.13 *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.
COMMENT: BUILDUP OF FOOD DEBRIS AND RESIDUES ON COUNTERS, CABINET, AND DRAWER SURFACES. CLEAN AND MAINTAIN CLEAN.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

! New Order: 4-700 Sanitizing Equipment and Utensils
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: 11/13/23-7/9/25: DISHWASHER ONSITE WITHOUT SANITIZING OPTION. 3-COMPARTMENT SINK NOT PRESENT. INSTALL DISHWASHER WITH THE ABILITY TO SANITIZE TO NSF/ANSI 184 STANDARDS OR INSTALL 3-COMPARTMENT SINK TO WASH, RINSE, AND SANITIZE BY JULY 25, 2025. IN THE INTERIM THE DISHWASHER CAN BE USED TO WASH AND RINSE EQUIPMENT AND UTENSILS BUT THE FINAL SANITIZING STEP MUST BE PERFORMED CHEMICALLY UNTIL THE INSTALLATION OF A SANITIZING NSF/ANSI 184 DISHWASHER. THE ESTABLISHMENT MAY USE THE NON-HANDWASHING SIDE OF THE 2-COMPARTMENT SINK OR A LARGE BASIN TO IMMERSE ITEMS IN SANITIZING SOLUTION. ESTABLISHMENT HAS LIQUID SODIUM HYPOCHLORITE WHICH CAN BE MIXED WITH WATER TO MAKE A SOLUTION WITH 50-200 PPM CONCENTRATION OF FREE CHLORINE.
Comply By: 11/13/2023 Originally Issued On: 7/9/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.111C *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.
COMMENT: ABUNDANCE OF MOUSE DROPPINGS ON FLOOR UNDER SINK, AROUND FLOOR PERIMETER, AND ON WINDOW SILL LEADING UP TO CORNER DRY STORAGE SHELVING AND ON DRY STORAGE SHELVING. MICE APPEAR TO BE CLIMBING UP THE CURTAIN BY THE WINDOW TO GET TO THE DRY STORAGE SHELVING AND BAGGED, BOXED, AND CANNED GOODS. OPERATOR INSTRUCTED TO IMPLEMENT PEST CONTROL MEASURES TO ELIMINATE THE PEST POPULATION.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: ABUNDANCE OF RODENT DROPPINGS IN KITCHEN. OPERATOR INSTRUCTED TO REMOVE DROPPINGS, CLEAN AND DISINFECT NON-FOOD-CONTACT SURFACES WHERE THE DROPPINGS ONCE WERE.
Comply By: 7/9/2025 Originally Issued On: 7/9/2025

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 Metro District Office inspection report number F1029251061 from 7/9/2025

Trevor McCliment

ISTAHIL ABDI
OPERATOR

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Duale Inc
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251061
Inspection Type: Full
Date: 7/9/2025
Time: 1:01:01 PM

New Record: **Product/Item/Unit:** BUTTER**; Temperature Process:** COLD HOLDING
Location: FRIDGE at 42 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** SOUR CREAM**; Temperature Process:** COLD HOLDING
Location: FRIDGE at 42 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Duale Inc
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251061
Inspection Type: Full
Date: 7/9/2025
Time: 1:01:01 PM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 0 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 0 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 50 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Equal To 100 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1029251061

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	3	Date: 7/9/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 1:01:01 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Duale Inc	1167 15th Ave SE	Minneapolis, MN	55414	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 36113		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	N/O	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	N/O	Hands clean and properly washed		
9	N/O	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	OUT	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors 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

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 **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	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38	X	Insects, rodents, & animals not present; no unauthorized person		
39	X	Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41	X	Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Person in Charge (signature)

Inspector (signature) Trevor McClime

Follow-up: Follow-up Date: