Electronically Delivered

September 19, 2024

Licensee
Careview Winchester Home
4207 Winchester Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL33522015

Dear Licensee:

On August 22, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 6, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

July 9, 2024

Licensee
Careview Winchester Home
4207 Winchester Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL33522015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is 3,000.00**. 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,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREVIEW WINCHESTER HOME	4207 WINCHESTER LANE BROOKLYN CENTER, MN 55429

(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: SL33522015-0 On June 3, 2024, through June 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents receiving services under the Assisted Living license. An immediate correction order was identified on June 5, 2024, issued for SL33522015-0, tag identification 0820. On June 5, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 3, 2024, at 10:45 a.m., registered nurse (RN)-A verified the licensee lacked a system for	0 460		

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0 460	Continued From page 2 residents to request staff assistance when needed 24 hours a day. RN-A stated residents are independent and call to ask for assistance when needed. On June 3, 2024, at 11:31 a.m., during the facility tour, the surveyor observed no system in place for residents to request staff assistance when needed 24 hours a day. On June 5, 2024, at 12:30 p.m., R4 stated they don't have a call light system, but they can call staff or yell for assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 480		

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0 480	Continued From page 3 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 June 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	0 650		

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0 650	Continued From page 4 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based interview and record review, the licensee failed to ensure the employee record contained the required content to include an annual performance evaluation for one of two employees (registered nurse (RN-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A was hired October 22, 2013, and provided direct cares for the residents of the facility. RN-A's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. On June 5, 2024, at 12:45 p.m., licensed assisted living director (LALD)-C verified RN-A's record lacked evidence of an annual performance review. LALD-C stated they are aware of the required annual performance review, and they were behind completing the annual performance evaluations.	0 650		

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0 650	Continued From page 5 The licensee's Employee Records policy dated September 1, 2022, indicated documentation of an annual performance review is required that identifies areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	Continued From page 6 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, 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). The findings include: On June 3, 2024, during the facility tour at approximately 11:31 a.m., the surveyor did not observe signage posted or information regarding the licensee's emergency plan. On June 3, 2024, 1:30 p.m., licensed assisted living director (LALD)-C provided Emergency Preparedness manual, undated. LALD-C confirmed the licensee lacked a customized emergency preparedness plan reviewed/updated annually which included the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the	0 680		

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0 680	Continued From page 7 licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; and - the facilities role in providing care and treatment at alternative sites. On June 3, 2024, at 2:15 p.m., LALD-C stated they are aware of require emergency preparedness and they have made some changes to policies and working on updating emergency preparedness. The licensee's Emergency Preparedness policy dated August 1, 2023, indicated [Licensee] would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 780	Continued From page 8	0 780		
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 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 780		

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0 780	Continued From page 9 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On June 05, 2024, at 9:45 a.m. survey staff toured the facility with director of nursing (DON)-A and house manager (HM)-D. Upon testing, it was found that the smoke alarms in the facility were not interconnected. These deficient conditions were visually verified by DON-A and HM-D accompanying on the tour. During interview, on June 05, 2024, at 1:30 p.m. DON-A stated they understood the smoke alarm requirements and would figure out how to get them interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	0 790		

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0 790	Continued From page 10 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 June 05, 2024, at 9:45 a.m. survey staff toured the facility with director of nursing (DON)-A and house manager (HM)-D. It was observed that the portable fire extinguishers in the kitchen was size 1-A:10-B:C, which does not comply with MN Statute 144G.45. It was observed that the portable fire extinguisher in the basement was size 3-A:40-B:C, but lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician.	0 790		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 11 During interview, on June 05, 2024, at 1:30 p.m., surveyor explained to DON-A and HM-D that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. DON-A and HM-D verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	06/06/2024

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0 800	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 05, 2024, at 9:45 a.m. survey staff toured the facility with director of nursing (DON)-A and house manager (HM)-D. The following was observed: Building Maintenance It was observed that there was significant damage to the walls in the living room and hallway to the bedrooms. Deep scrapes and holes were identified on both sides of the hallway for the entire length. It was observed in multiple locations that the wood trim at the doorways was damaged and in some locations missing completely, exposing protruding nails into the narrow hallway. It was observed that the main level bedroom and bathroom doors were heavily damaged, scraped, and stained with dark stains. Some of the staining appeared to be oil and dirt that had accumulated over time, while some of the other staining appeared to be from friction caused by equipment or other heavy object. It was observed that the floor in the hallway to the bedrooms was heavily stained black on each side	0 800		

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0 800	Continued From page 13 and around all the door frames. During interview, on June 05, 2024, at 1:30 p.m., DON-A stated that some of the residents use wheelchairs and have a difficult time navigating in the house without scraping and punching holes in the walls. DON-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 14 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 05, 2024, director of nursing (DON)-A and house manager (HM)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Policy", undated, lacked the following:	0 810		

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0 810	Continued From page 15 The FSEP included standard administrative responsibilities for fire safety, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan indicated that staff should "not panic" and "call 911", but failed to include any procedures for how staff are to evacuate the building. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During interview, on June 05, 2024, at 1:30 p.m., DON-A and HM-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. DON-A and HM-D were unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. DON-A and	0 810		

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0 810	Continued From page 16 HM-D were unable to provide documentation showing any training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. During interview, on June 05, 2024, at 1:30 p.m., DON-A and HM-D stated he was doing the training at the same time that they completed the evacuation/ fire drills. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated evacuation drills were completed on 03/19/2024, 04/01/2024, 04/08/2024, and 05/20/2024. No other documentation was provided. During interview, on June 05, 2024, at 1:30 p.m., DON-A and HM-D stated there were no further documented drills for the facility and verified this deficient condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any	0 820		

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0 820	Continued From page 17 existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 05, 2024, at 9:45 a.m. survey staff toured the facility with director of nursing (DON)-A and house manager (HM)-D. During the tour, survey staff asked DON-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Occupied Sleeping Rooms: Bedroom #1 occupied by R1: One window	0 820	This immediate correction order identified on June 05, 2024, has had the immediacy lifted as of June 05, 2024, however non-compliance remained a scope and level of I.	

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0 820	Continued From page 18 measuring 36 inches clear width, 14 inches clear height, and 504 square inches total open area. Bedroom #2 occupied by R2: Two windows measuring 28 inches clear width, 14 inches clear height, and 392 square inches total open area for each window. Bedroom #3 occupied by R3: One window measuring 29 inches clear width, 13 inches clear height, and 377 square inches total open area. One window measuring 28 inches clear width, 11.5 inches clear height, and 322 square inches total open area. Bedroom #4 occupied by R4: one window measuring 36 inches clear width, 13.5 inches clear height, and 486 square inches total open area. The windows in bedrooms #1, #2, #3, #4 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to DON-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. DON-A verbally confirmed the findings. On June 06, 2024, survey staff explained to DON-A that an immediate correction order was issued for the above finding. DON-A acknowledged the above finding.	0 820		

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0 820	Continued From page 19 No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate On June 5, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970		

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0 970	Continued From page 20 The findings include: On June 2, 2024, at approximately 1:30 p.m., licensed assisted living director (LALD)-C provided a blank Assisted Living Contract, undated, and indicated the contract is used by licensee for all residents who received services. The Assisted Living Contract included a section titled Indemnification that stated "[Licensee] shall not be liable for any damage or injury to the resident or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by the negligence of [licensee]." On June 5, 2024, at 1:30 p.m., LALD-C acknowledged the licensee's assisted living contract included a waiver of liability for health and safety or personal property. LALD-C stated "we removed waiver of liability our new contract, but the old contract still got used. We reorganized all forms so that the old one does not get used". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=F	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	01290		

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01290	Continued From page 21 construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under 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 affiliated to the licensee's health facility identification (HFID) number prior to providing services to residents for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-A was hired October 22, 2013, under the licensee's comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's employee record contained a background study dated May 6, 2014, that was affiliated with the licensee's previously held comprehensive	01290		

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01290	Continued From page 22 home care license. RN-A's employee record lacked evidence the licensee affiliated a background study for RN-A under the current HFID. ULP-B was hired December 2, 2019, under the licensee's comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee record contained a background study dated December 2, 2019, that was affiliated with the licensee's previously held comprehensive home care license. ULP-B's employee record lacked evidence the licensee affiliated a background study for ULP-B under the current HFID. On June 5, 2024, at 1:00 p.m., licensed assisted living director (LALD)-C stated the licensee had not affiliated RN-A and ULP-B's background studies to the current HFID. Also, LALD-C stated they are working to ensure all staff's background studies were affiliated to the licensee's HFID prior to providing services to residents. The licensee's Background Studies policy dated September 1, 2022, indicated [License] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [License]. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 23 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01620		

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01620	Continued From page 24 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 4, 2024, at 12:03 p.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R4. R4 admitted to the licensee on May 14, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R4's diagnoses included diabetes, chronic pain, low back pain, and substance abuse. R4's Service plan dated April 1, 2024, indicated R4 received services which included assistance with dressing, grooming, showers, meals, medication administration, blood pressure check, blood glucose monitor, behavior management, housekeeping, and laundry. R4's 90 Day Home Care Assessment/Skilled Care Notes dated January 14, 2024, and April 14, 2024, lacked ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool. On June 5, 2024, at 1:00 p.m., RN-A verified the document Nurse Reassessment lacked the required content listed. RN-A provided uniform assessment completed for R4 and RN-A stated they completed the uniform assessment tool during initial assessments and all ongoing assessments used a short form and was not aware of the uniform assessment tool was	01620		

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CAREVIEW WINCHESTER HOME	4207 WINCHESTER LANE BROOKLYN CENTER, MN 55429

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01620	Continued From page 25 required every 90 days. RN-A also stated they do use uniform assessment tool during initial assessment and all the other residents' reassessments completed using short form - 90 Day Home Care Assessment/ Skilled Care Note. Minnesota Administrative Rule 4659.0140, subpart 2, B., (3) dated August 11, 2021, indicated the nursing assessment or reassessment must be conducted using a uniform assessment tool that complied with part 4659.0150. Minnesota Administrative Rule 4659.0150, subpart 2 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated September 1, 2022, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREVIEW WINCHESTER HOME	4207 WINCHESTER LANE BROOKLYN CENTER, MN 55429

(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
01890	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not expired for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 3, 2024, at 11:35 a.m., the surveyor observed R4's medication box. There was an opened insulin pen (Lantus Solostar) labeled with an open date of May 5, 2024, which were past the manufacturer's use by date of May 30, 2024. House manager (HM)-D stated the licensee's staff always label when they open insulin and discard after 30 days. HM-D also stated they are waiting for a refill of medications from the pharmacy this week. R4's medication administration record (MAR) indicated Lantus Solostar was given daily at bedtime form May 30, 2024, through June 3, 2024, which were past the manufacturer's use by date of May 30, 2024. R4's physician orders dated May 1, 2024, indicated R4's prescriptions included: Lantus Solostar, inject 55 units subcutaneously daily at bedtime.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREVIEW WINCHESTER HOME	4207 WINCHESTER LANE BROOKLYN CENTER, MN 55429

(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
01890	Continued From page 27 The manufacturer's instructions for Lantus dated August 2022, directed to discard the pen 28 days after opening, even if it had insulin in it. On June 5, 2024, at 1:00 p.m., registered nurse (RN)-A stated all resident medications were labeled and the nurses check to ensure they are not expired. RN-A stated they have a process in place for expired medications, but this was missed. RN-A also stated he notified the physician and resident about the expired medication and replaced with unexpired medication. RN-A also stated they must retrain staff. The licensee's Medication and Treatment policy dated September 1, 2022, indicated expired medications managed by [Licensee] will disposed of according to the acceptable practices. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *06/04/24*
Time: 11:10:19
Report: 7994241104

Food and Beverage Establishment Inspection Report

Location:

Careview Winchester Home
4207 Winchester Lane
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038438
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129105473
ID #:

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

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

PAPER TOWELS NOT PROVIDED NEAR HANDWASH SINK.

Comply By: 06/04/24

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

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

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS LAMINATE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS ANDSMOOTH CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

Type: Full
Date: *06/04/24*
Time: 11:10:19
Report: 7994241104
Careview Winchester Home

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994241104 of 06/04/24.

Certified Food Protection Manager: Alloys Onkundi

Certification Number: 120012 Expires: 11/11/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

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

Report #: 7994241104

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 06/04/24
Time In 11:10:19
Time Out

Careview Winchester Home	**Address** 4207 Winchester Lane	**City/State** Brooklyn Center, MN	**Zip Code** 55429	**Telephone** 6129105473
License/Permit # 0038438	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 06/04/24

Inspector (Signature) Crystal Elva