Electronically Delivered

May 2, 2024

Licensee
Midwest Residential Inc.
10325 Zinran Avenue South
Bloomington, MN 55438

RE: Project Number(s) SL37547015

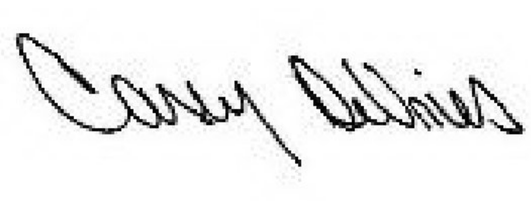
Dear Licensee:

On April 18, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 22, 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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37547	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST RESIDENTIAL INC	10325 ZINRAN AVENUE SOUTH BLOOMINGTON, MN 55438

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL37547015-1 On April 18, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed February 19, 2024, through February 21,2024. At the time of the survey, there were 5 active residents receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	{0 660}		

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{0 660}	Continued From page 1 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 660}		
{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: No further action required.	{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	{0 810}		

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{0 810}	Continued From page 2 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 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: No further action required.	{0 810}		
{01060} SS=D	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.	{01060}		

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

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{01060}	Continued From page 4 No further action required.	{01060}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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: No further action required.	{01620}		

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March 7, 2024

Licensee
Midwest Residential, Inc.
10325 Zinran Avenue South
Bloomington, MN 55438

RE: Project Number(s) SL37547015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 22, 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 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements = $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. 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,

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

PMB

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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: SL37547015-0 On February 20, 2024, through February 22, 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 five residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on February 20, 2024, issued for SL37547015-0, tag identification 0470. On February 21, 2024, the immediacy of correction order 0470 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on February 21, 2024, issued for SL37547015-0, tag identification 2310.	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.	

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0 000	Continued From page 1 On February 22, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	0 470		

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0 470	Continued From page 2 Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing to meet the needs of two of two residents (R1, R2), who required two-person transfers with a mechanical lift. 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: The licensee lacked sufficient staffing to meet R1 and R2's needs on a 24-hour basis as required by the resident assessment and service plan. The licensee's current staffing plan dated October 17, 2023, indicated the licensee had two staff present for all three meals and two staff present for all transfers for activities of daily living (ADLs) for non-ambulatory residents. The plan indicated the staffing requirements included two direct care staff for morning shift, two direct care staff for evening shift, and one awake and one on-call staff person for night shift. The licensee's employee schedule for the week of February 18, 2024, indicated one ULP for the night shift with no indication of an on-call staff person. R1 R1's diagnoses included quadriplegia, Friedreich ataxia, muscle spasm, and diabetes mellitus.	0 470		

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0 470	Continued From page 3 R1's signed service plan, dated August 1, 2021, indicated R1 required a two-person assist for transfers. R1's 90-day nursing reassessment form, dated December 11, 2023, indicated R1 required an assist of two for transfer with a mechanical lift. R1's face sheet, printed February 20, 2024, indicated R1 required full-service assist to evacuate in case of an emergency. The face sheet indicated R1 was categorized, "level 1: high priority", and, "In case of a disaster or emergency, this client may not be left unattended." R2 R2's diagnoses included spina bifida, Amold-Chiari syndrome, and hydrocephalus. R2's signed service plan, dated June 6, 2023, indicated R2 required a two-person assist for transfers. R2's 90-day nursing reassessment form, dated January 30, 2024, indicated R2 required an assist of two for transfer with mechanical lift. R2's face sheet, printed February 19, 2024, indicated R2 required a wheelchair for evacuation in case of an emergency. The face sheet also indicated R2 was categorized, "level 2: Moderate priority: services for clients at this priority level may be postponed for several hours". On February 20, 2024, 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated two unlicensed personnel (ULP) were scheduled from 7:00 a.m., to 3:00 p.m., two ULP were scheduled from 3:00	0 470		

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0 470	Continued From page 4 p.m., to 11:00 p.m., and one ULP was scheduled from 11:00 p.m., to 7:00 a.m., with additional on call support staff if needed. LALD-D stated the on-call staff resided 7 to 12 minutes away from the facility, depending on which staff member was on call. On February 20, 2024, at 12:03 p.m., ULP-A stated nobody got up at night, and they would call the supervisor if they had to get a resident up at night. ULP-A stated they were not allowed to do one-person transfers unless it was an emergency. ULP-A stated in case of a fire or emergency they would perform the transfer on their own, if they were physically able to do so. On February 20, 2024, at 12:25 p.m., R1 stated they were told by LALD-D to not get up at night because they only had one staff working at night. On February 20, 2024, at 1:40 p.m., clinical nurse supervisor (CNS)-B stated their policy for mechanical lift transfer was to always use two ULPs. CNS-B stated in the event of emergency, ULPs would have to evacuate the residents using one-person assist. CNS-B stated if R1 needed to use the bathroom or commode at night, ULPs could do a one-person transfer. The surveyor inquired if it was appropriate for the ULPs to use their own discretion as to when to use one staff versus two to transfer. CNS-B stated ULPs should not be making the decision on their own. On February 20, 2024, at 2:33 p.m., the surveyor requested a policy and procedure for use of mechanical lift. LALD-D stated they were trying to find it; they bought the policies from Care Providers, and they could not find it at the moment. They placed a call to Care Providers and were waiting for a call back.	0 470		

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0 470	Continued From page 5 The manufacturer recommendation for Invacare Reliant 450 Hoyer lift read: "Although Invacare recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case." The licensees Training and Competency form for Hoyer Lift and EZ stand did not indicate how many staff persons should operate the equipment. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two hours of annual tuberculosis (TB) training was completed for one of one employee (unlicensed personnel (ULP)-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) 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: ULP-A was hired on September 12, 2022, to provide direct cares to residents. ULP-A's employee record lacked annual TB training. It included a TB Training Acknowledgement form completed on October 1, 2022, which acknowledged completion of TB training at the time of hire. ULP-A's Educare (online training platform) transcript indicated their last TB training had been completed on January 16, 2023, under the OSHA and Infection Control - BELTSS training module. Annual TB training was due to be completed by January 16, 2024. On February 20, 2024, at 12:03 p.m., during a phone interview, ULP-A stated they worked the overnight shift at the facility providing direct cares to residents. On February 22, 2024, at 9:00 a.m., clinical nurse supervisor (CNS)-B stated ULP-A should have had annual TB training completed. CNS-B stated	0 660		

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0 660	Continued From page 7 they would look into it to see if they could find further training documentation. On February 22, 2024, at 9:16 a.m., licensed assisted living director (LALD)-C stated staff annual TB training wasn't a requirement and wanted to see where it was addressed in the state statutes. On February 22, 2024, at 9:46 a.m., CNS-B stated they were unaware of the annual TB training requirements and had been unable to locate further TB training documentation for ULP-A but would continue to search their records. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should receive TB education annually. The Minnesota Department of Health TB FAQ indicated each provider licensed by MDH is required to complete a TB risk assessment annually. Further, all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. The licensee's TB risk assessment completed on August 1, 2023, indicated the licensee was at a low risk level. It further indicated, "All Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure (both occupational and nonoccupational) risk factors, the signs and symptoms of TB disease, and TB infection control policies and procedures." The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated:	0 660		

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0 660	Continued From page 8 "Staff will be educated regarding TB at time of hire. The content of the training should be appropriate to the job responsibilities and educational or professional background of the employee (licensed versus unlicensed staff). Content of the training will focus on basic information about: 1. TB pathogenesis and transmission, 2. Signs and symptoms of active TB disease, and 3. Midwest Residential infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 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	0 800		

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0 800	Continued From page 9 affect all residents and staff. 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 February 22, 2024, at 12:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C and quality assurance personnel (QA)-E. During the facility tour, survey staff observed the following items: It was observed on the patio, outside of the exit door to the backyard, that burnt used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. In the living room on the lower level, it was observed that there was a hole in the acoustic ceiling tile. In the bathroom on the lower level, it was observed that the body of the exhaust fan was not connected to any duct or exhaust system. The bathroom exhaust fan should be vented directly outside the facility. It was also observed that the acoustic ceiling tiles were sagging badly, with evidence of water damage. In the laundry room on the lower level, it was observed that the ceiling tiles were sagging badly, with evidence of water damage.	0 800		

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0 800	Continued From page 10 On February 22, 2024, at 12:00 p.m., LALD-C verified there was not a fire-safe disposal container for smoking residents. LALD-C also confirmed those damaged ceilings were not in good repair, and the exhausted fan was not well maintained in the bathroom on the lower level. 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 training shall be made available to residents at least once per year.	0 810		

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0 810	Continued From page 11 (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 interview and record review, the licensee failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 22, 2024, at 12:00 p.m., the licensed assisted living director (LALD)-C and quality assurance personnel (QA)-E provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated employees did not receive training twice per year after initial hire.	0 810		

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0 810	Continued From page 12 During the interview on February 22, 2024, at 12:00 p.m., LALD-C stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-C confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	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 13 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 required content for an emergency relocation for one of one resident (R2) with records reviewed. 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: R2 admitted to the licensee on June 21, 2023, and began receiving assisted living services.	01060		

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01060	Continued From page 14 R2's diagnosis included spina bifida, Amold-Chiari syndrome, and hydrocephalus. R2's signed Service Plan Form, dated June 6, 2023, indicated R2 received assistance with medication administration, bathing, dressing, grooming, housekeeping, laundry, meals assistant, transfers, mobility, and safety checks. R2's Leave of Absence Information undated, indicated the licensee sent R2 to the Fairview Hospital on January 26, 2024, for not feeling well, and R2 returned to the facility on January 29, 2024. R2's record lacked evidence a written notice was provided that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - 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; - 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01620	Continued From page 15	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01620		

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01620	Continued From page 16 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee on June 21, 2023, and began receiving assisted living services. R2's diagnosis included spina bifida, Amold-Chiari syndrome, and hydrocephalus. R2's signed service plan form, dated June 6, 2023, indicated R2 received assistance with medication administration, bathing, dressing, grooming, housekeeping, laundry, meals assistant, transfers, mobility, and safety checks. R2's record included 90-day nursing assessments dated October 1, 2023, and January 30, 2024. The assessment completed on January 30, 2024, was 32 days past the 90-calendar day requirement. On February 22, 2024, at 10:25 a.m., clinical nurse supervisor (CNS)-B stated they completed the assessment based on the date calculated by elder mark (electronic medical record software). CNS-B stated they were misled by the due date generated by elder mark. The licensee's 6.01 Assessment Reviews & Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided.	01620		

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01620	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R1) with consumer bedrails. This resulted in an immediate correction order on February 21, 2024. 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 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: R1's diagnoses included quadriplegia, Friedreich ataxia, muscle spasm, and diabetes mellitus. R1's signed service plan, dated August 1, 2021,	02310		

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02310	Continued From page 18 indicated R1 received services including assistance with bathing, dining, grooming, medication administration, toileting, and transferring. R1's 90 day 6.045 nursing reassessment form completed December 11, 2023, indicated R1 had bed rails in place. R1's record included a side rail assessment form, dated May 12, 2022, that indicated R1 used bilateral side rails for positioning or support, and to promote independence. On February 20, 2024, at 12:25 p.m., the surveyor observed R1's hospital-style bed with bilateral upper half hospital-style bed rails and a consumer grab bar on the right lower side of the bed (toward the foot of the bed). The consumer grab bar was an upside down-U shaped bar with a black mesh across the middle opening. The grab bar manufacturer name, "AOHHL," was printed on the outer side of the mesh. R1's bed was noted to be in a lowered position. The surveyor wiggled and pulled on the bedrails and grab bar, which were firmly attached to the bed. On February 21, 2024, at approximately 8:30 a.m., licensed assisted living director (LALD)-D stated R1's doctor refused to write an order for the consumer grab bar. LALD-D stated they took a picture of the grab bar and faxed it to the doctor and got a verbal "ok" to use the grab bar from the doctor's office. On February 21, 2024, at 8:35 a.m., R1 stated they bought the consumer grab bar and had it installed on the bed Friday, February 16, 2024. R1's record lacked documentation of an	02310		

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02310	Continued From page 19 assessment related to R1's use of the consumer grab bar installed February 16, 2024, including the following: -Purpose and intention of the bed rail; -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -The resident's bed rail use/need assessment; -The resident's preferences; -Installation and use according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R1's record also lacked documentation the licensee checked the consumer product safety commission recall list to make sure there was no active recall on the grab bar. On February 21, 2024, at 10:18 a.m., clinical nurse supervisor (CNS)-B stated they thought R1's family installed the grab bar, stating, "I do not think facility staff did it. It is probably her father." CNS-B stated staff reported there was a grab bar installed on R1's bed and CNS-B came in and saw it. CNS-B also stated they had R1 sign a Resident Bed Rail Consent Form and Risk versus Benefit form on Monday February 19, 2024. Surveyor inquired if they had consulted the manufacturer instruction. CNS-B stated they did not have any of the manufacturer's information as the boxes were thrown away by R1 and her family. CNS-B also stated there was no manufacturer indicated on the grab bar and they were unable to ask family because R1 was their own person and resident did not consent for her	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37547	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST RESIDENTIAL INC	10325 ZINRAN AVENUE SOUTH BLOOMINGTON, MN 55438

(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
02310	Continued From page 20 family to be contacted. CNS-B stated they completed a bedrail assessment for the hospital-style bed rails in December and R1 was not due for another one. Surveyor further inquired if an assessment was done for the new bedrail (grab bar). CNS-B stated they were waiting on the physician order to see if it was ok for the resident to use the bedrail. CNS-B also stated they did not check to see if there was a recall on the grab bar. On February 21, 2024, at 12:15 p.m., LALD-D stated the grab bar was installed on Friday (February 16, 2024) by the facility staff. On February 21, 2024, at 1:20 p.m., LALD-D stated R1 bought the consumer grab bar online. On February 21, 2024, at 2:45 p.m., R1 stated one of the girls (referring to staff members) installed the grab bar. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) Resource and Frequently Asked Questions (FAQs) related to consumer bedrails assessment, updated February 20, 2024, indicated the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37547	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST RESIDENTIAL INC	10325 ZINRAN AVENUE SOUTH BLOOMINGTON, MN 55438

(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
02310	Continued From page 21 following required items: -Purpose and intention of the bed rail; -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -The resident's bed rail use/need assessment; -Risk vs. benefits discussion (individualized to each resident's risks); -The resident's preferences; -Installation and use according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements The licensee's 6.28 Side Rails Policy last reviewed and revised on August 1, 2021, read: " POLICY: When [Licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [Licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *02/21/24*
Time: 13:16:43
Report: 7963241018

Food and Beverage Establishment Inspection Report

Location:
Midwest Residential Inc
10325 Zinran Avenue South
Bloomington, MN55438
Hennepin County, 27

Establishment Info:
ID #: 0039048
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513152649
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.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST ORIGINAL COPY OF CERTIFICATE ON SITE.

Comply By: 02/21/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: No

Hot Water: = at 170 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Food and Equipment Temperatures

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

Process/Item: YOGURT
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Type: Full
Date: *02/21/24*
Time: 13:16:43
Report: 7963241018
Midwest Residential Inc

Food and Beverage Establishment Inspection Report

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

MET WITH HRD SURVEYORS DEE MOSISSA AND JOEY KEEN. MET WITH FACILITY REPRESENTATIVE FAIZA HASSAN. DISCUSSED THE FOLLOWING-

-EMPLOYEE HEALTH POLICY AND LOG
-BARE HAND CONTACT
-SANITIZING OF SURFACES AND DISHES
-FOOD STORAGE
-VOMIT AND FECAL CLEAN UP POLICY

THIS IS A RESIDENTIAL KITCHEN DOING SAME DAY FOOD SERVICE.

A DISHWASHER WITH A SANITIZER CYCLE IS USED FOR DISH/UTENSIL CLEANING AND SANITIZING.

KITCHEN HAS A CERAMIC FLOOR, WOOD CABINETS WITH LAMINATE COUNTERTOPS AND A POPCORN CEILING.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7963241018 of 02/21/24.

Certified Food Protection Manager: Faiza Hassan

Certification Number: FM 108405 Expires: 09/26/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Faiza Hassan
PIC

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

Report #: 7963241018

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

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

Date 02/21/24
Time In 13:16:43
Time Out

Midwest Residential Inc	Address: 10325 Zinran Avenue South	City/State: Bloomington, MN	Zip Code: 55438	Telephone: 6513152649
License/Permit #: 0039048	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:** 02/21/24

Inspector (Signature) Peggy Spudy