DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 11, 2023

Licensee
Minnesota Greenleaf
1006 Greenwood Street East
Thief River Falls, MN 56701

RE: Project Number(s) SL30342015

Dear Licensee:

On December 16, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 15, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

HHH

Electronically Delivered

October 13, 2022

Administrator
Minnesota Greenleaf
1006 Greenwood Street East
Thief River Falls, MN 56701

RE: Project Number(s) SL30342015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 15, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration = $3,000

The total amount you are assessed is $3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit

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

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

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30342	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GREENLEAF	1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701

(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 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: SL30342015 On August 13, 2022, through August 15, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were fifty-three (53) residents receiving services under the provider's Assisted Living Dementia Care license. On September 14, 2022, the immediacy of correction order 1750 has been removed, however non-compliance remains at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 had the potential to affect all residents in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report,	0 480		

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0 480	Continued From page 2 dated September 14, 2022 , for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for three of three unlicensed personnel ((ULP)-B, (ULP)-E, (ULP)-F) providing personal cares. In addition, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect all fifty-three (53) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	0 510		

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0 510	Continued From page 3	0 510		

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:

COVID-19 SCREENING
On September 13, 2022, at 9:00 a.m., the surveyor entered the licensee's establishment and walked into the common entry area. There were no staff present at the time the surveyor entered building. The surveyor began walking toward a door that was labeled office and was greeted by a staff member wearing a face mask covering their nose and mouth. The staff member did not screen the surveyor for signs and symptoms of COVID-19 or perform a temperature check. The surveyor then was told to wait in area and the staff member would get assisted living director (ALD)-D. ALD-D was wearing a face mask covering the nose and mouth.

During entrance conference on September 13, 2022, at 9:45 a.m., registered nurse (RN)-A stated she believed that current guidelines indicated staff were to wear a mask and eye protection. RN-A stated she had not reviewed the current transmission rates for COVID-19 cases. RN-A stated everyone entering the establishment were to self-screen for COVID-19 and complete a form that was at the reception desk.

During observation on September 13, 2022, at approximately 10:35 a.m., a visitor entered the building, was not wearing a mask, walked past the reception desk, and proceeded to go through a closed-door area.

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0 510	Continued From page 4 PERSONAL PROTECTIVE EQUIPMENT (PPE): GLOVES/HANDWASHING On September 13, 2022, at 11:10 a.m., ULP-E performed medication administration and blood glucose testing for R4. ULP-E stated she washed her hands before the surveyor began observation. ULP-E stated the licensee was out of hand sanitizer, so she washed her hands with soap and water. ULP-E gathered blood glucose testing supplies. ULP-E applied one glove to her non dominant hand and proceeded to walk to R4. ULP-E opened an alcohol wipe and wiped R4's middle right finger. Using gloved hand, ULP-E squeezed finger until blood was visible and using non gloved hand placed blood collection strip to drop of blood until blood collected onto strip. ULP-E gave R4 a tissue to hold to finger to stop bleeding. ULP-E placed collection strip with blood sample into blood glucose monitor using non gloved hand. ULP-E then proceeded to return to med cart, removed glove, did not wash hands, obtained insulin pen from refrigerator, removed cap, obtained a sealed insulin pen needle and alcohol wipe from med cart, wiped top of insulin pen with alcohol wipe, placed insulin pen needle onto insulin pen, dialed insulin pen to 2, depressed button on insulin pen until dial went to 0, dialed insulin pen to 14, applied a glove to dominant hand. ULP-E then proceeded to return to R4, lifted R4's shirt, removed alcohol wipe from wrapper, wiped abdomen with alcohol wipe, inserted insulin pen needle into abdomen, depressed button on insulin pen and held until insulin pen's dial turned to zero. ULP-E covered R4's abdomen with shirt, proceeded to return to medication cart, did not wash hands, documented administration on an electronic device, proceeded to obtain a medication cup from the supply on the medication cup. The surveyor then requested	0 510		

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0 510	Continued From page 5 that ULP-E stop her process and explained to ULP-E the process needed to complete hand washing during medication administration. PERSONAL PROTECTIVE EQUIPMENT: MASKS During observation on September 13, 2022, at approximately 11:15 a.m., ULP-B and ULP-F entered the dining area wearing a face mask that covered the mouth but did not cover the nose. Both ULP-B and ULP-F began conversing and distributing drinks to residents sitting at dining tables. During interview on September 13, 2022, at 11:20 a.m., ULP-B was asked if she knew the proper procedure for wearing a face mask. ULP-B stated she did know the procedure but stated she had a difficult time wearing the mask over her nose because she had asthma. During same interview, ULP-F stated she also had asthma and it was difficult to wear the mask over her nose. At the end of the interview, ULP-B and ULP-F placed their face mask over their nose and mouth. During interview on September 13, 2022, at 11:30 a.m., the surveyor explained to RN-A what observations were seen with ULP-B and ULP-F in the dining area. RN-A stated they have been educated that they must wear a face mask over their nose and mouth during times of providing resident care. RN-A stated she would re-educate both staff members. The Minnesota Statewide Community Transmission level for the week of September 13, 2022, indicated the level was low transmission for Pennington County.	0 510		

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0 510	Continued From page 6 The Minnesota Department of Health's COVID-19 PPE and Source Control Grids dated April 7, 2022, indicated all employees who work in a congregated health care setting, including assisted living facilities, are recommended to wear a face mask and eye protection when in areas they could encounter residents. The licensee's Handwashing and Sanitizing policy, dated January 1, 2017, indicated hands must be washed thoroughly with antimicrobial soap and water, including but are not limited to before and after assisting residents or staff with any contact with bodily fluids, blood, mucous membranes, non-intact skin, or any other contaminated surfaces and before and after gloving. The licensee's Personal Protective Equipment policy, undated, indicated gloves are single-use items and should be used for invasive procedures including contact with sterile sites, non-intact skin or mucous membranes, and for activities that have been assessed as carrying a risk of exposure to blood, body fluid or infectious respired aerosols or droplets. They must be put on immediately before an episode of client contact or treatment. The licensee's Pandemic Infectious Disease-COVID 19 policy, revised August 2021, indicated surgical masks should be worn at all times within the facility. The policy did not indicate current CDC guidance in regards to COVID-19 screening of visitors. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		

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0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights;	0 730		

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0 730	Continued From page 8 (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5 admitted for services on September 11, 2021, and discharged on October 29, 2021. R5's record contained a progress note that indicated the resident had discharged but lacked the following required content: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that	0 730		

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0 730	Continued From page 9 includes the resident status, including baseline and current mental, behavioral, and functional status; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and non-medical services the resident will need. On September 13, 2022, at approximately 3:00 p.m., registered nurse (RN)-A confirmed the discharge summary lacked all the required content. RN-A stated that she and other nursing staff are responsible to ensure the discharge summary and the medication disposition process is completed when a resident is discharged. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 10 Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all residents). The findings include: On September 13, 2022, from approximately 10:30 a.m. to 12:30 p.m., survey staff toured the facility with Assisted Living Director (ALD)-C. During the facility tour, survey staff observed and verified the following maintenance issues: 1. Shower curtain rod, in resident bathroom 102, was falling off the wall. 2. The fire rated doors in some of the residents' rooms and in the hallway by the mechanical room was propped open with a door wedge. ALD-C verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30342	A. BUILDING: _____ B. WING _____	09/15/2022

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0 900	Continued From page 11	0 900		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 11, 2019, and discharged to another location on August 8, 2021. R1's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing and (2) assisted living services, whether provided directly by the licensee or by management agreement or other agreement. In addition, R1's records lacked evidence that the contract had been fully executed as the licensee must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a completed unsigned copy of its contract; - give a completed copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has	0 900		

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0 900	Continued From page 13 been signed; and - the licensee must offer the resident the opportunity to identify a designated representative. On September 13, 2022, at approximately 3:15 p.m., registered nurse (RN)-A, acknowledged R1 lacked a current written contract for the current Assisted Living Dementia Care licensure requirements. RN-A stated all residents received a new contract when the statutes had changed in August 2021. RN-A was not sure why R1 didn't receive a new contract at that time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and	01370		

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01370	Continued From page 14 (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel ((ULP)-B), to include all required content. 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).	01370		

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01370	Continued From page 15 The findings include: ULP- B was hired on August 25, 2022. ULP-B's training record lacked documentation of completed training and competency for the following: -maintenance of a clean and safe environment and -commonly used assistive devices. On September 13, 2022, at approximately 11:20 a.m., registered nurse (RN)-A acknowledged ULP-B's record lacked documentation of the required training. RN-A stated the training documentation lacking would have been completed onsite during orientation and orientation was conducted by an RN that was previously employed for licensee. The licensee's training and competency policy were requested but not received. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 16 appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel ((ULP)-B), to include all required content. 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: ULP-B had a hire date of August 25, 2022. ULP-B's employee record lacked documentation of completed training and competency for the following: - observation, reporting, and documenting status, - basic body knowledge, - recognizing needs, - safe transfers, and - range of motion.	01380		

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01380	Continued From page 17 On September 13, 2022, at approximately 11:20 a.m., registered nurse (RN)-A acknowledged ULP-B's record lacked documentation of the required training. RN-A stated the training documentation lacking would have been completed onsite during orientation and orientation was conducted by an RN that was previously employed for licensee. The licensee's training and competency policy were requested but not received. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced	01420		

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01420	Continued From page 18 by: Based on interview and record review, the licensee failed to ensure the employee record contained training and competency evaluations for one of one unlicensed personnel ((ULP)-B) who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of August 25, 2022. ULP-B's record lacked any documentation that training and competency testing in delegated tasks had been completed. During interview on September 13, 2022, at 12:00 p.m., registered nurse (RN)-A stated the previous RN had left her position without notice and RN-A believes there were staff that may have not received all required training. RN-A stated she was in the process of developing the licensee's training program for all staff. The licensee's Orientation and Annual Training and Competency Requirements policy, dated July 2022, indicated unlicensed personnel providing assisted living services must have successfully completed a training and competency evaluation appropriate to the services being provided. The policy also indicated unlicensed staff performing delegated nursing or therapy tasks must be trained in the proper methods and follow the	01420		

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01420	Continued From page 19 procedures to perform the tasks. If the unlicensed personnel has not regularly performed the delegated task for a period of 24 months they must demonstrate competency with the nurse or appropriate licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	01420		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	01440		

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01440	Continued From page 20 by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days of providing services for one of one 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 of the residents). The findings include: ULP-B had a hire date of August 25, 2022. ULP-B was hired to provide direct care and services to the licensee's residents. ULP-B's employee record lacked documentation of an RN supervising ULP-B performing delegated tasks within 30 days of beginning work with the licensee. ULP-B's employee record lacked verification that the work was performed competently and to identify problems and solutions to address issues relating to ULP-B's ability to provide the services. During an interview on September 13, 2022, at 2:15 p.m., RN-A stated she was unaware as to why ULP-B did not have required documentation. RN-A stated that a previous RN completed the training and competencies for ULP's and no longer worked for licensee. No further information was provided.	01440		

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01440	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training in the required areas for one of one employee (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 of the residents). The findings include: ULP-B started employment with the licensee on August 25, 2022. ULP-B's employee file lacked evidence of completing dementia care training in the topics: - an explanation of Alzheimer's disease and other dementia's; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and	01490		

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01490	Continued From page 22 - person-centered planning and service delivery. On September 13, 2022, at approximately 11:45 a.m., registered nurse (RN)-A acknowledged ULP-B 's file was missing dementia care training and stated ULP-B was in the process of completing this education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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 training and competency evaluations for one of one unlicensed personnel ((ULP)-B) who performed the delegated task of medication administration. This practice resulted in a level three violation (a	01750		

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01750	Continued From page 23	01750		

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:

ULP-B started employment with the licensee on August 25, 2022. ULP-B's employee record lacked evidence of completed training and competency evaluation for medication administration by a RN or other licensed health professional.

On September 13, 2022, at approximately 11:00 a.m., RN-A stated ULP-B had not been trained in the above identified areas prior to providing services to residents.

On September 13, 2022, at approximately 12:30 p.m., ULP-B stated they were trained in the procedure of medication administration by another ULP employed by licensee. ULP-B stated she could not remember the name of the ULP but knows that a registered nurse did not train her to administer medication.

On September 13, 2022, at approximately 12:50 p.m., RN-A acknowledged that ULP-B had been trained by another ULP and had not received RN training in medication administration. RN-A stated that licensee was in the process of developing and implementing a training program and that said training was to be started within the next week.

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01750	Continued From page 24 The licensee's training and competency policy was requested but not obtained. No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed based on surveyor observation and review by evaluation supervisor on September 14, 2022, however, noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30342	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GREENLEAF	1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701

(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
01910	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an 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: R5's Service Plan dated October 20, 2021, indicated R5 received medication administration services daily. R5's medical record included a discharge summary which indicated R5 discharged from the facility on May 10, 2022. R5's record lacked documentation of medication disposition upon discharge from facility. On September 13, 2022, at approximately 1:08 p.m., registered nurse (RN)-A acknowledged R5's did not have a discharge summary and did not include to include quantity and names of staff and other individuals involved in the disposition of medications.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30342	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GREENLEAF	1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701

(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
01910	Continued From page 26 The licensee's Disposition and Disposal of Medications policy, dated August 1, 2021, indicated upon disposition, the licensee would document information in the clinical record to include name, strength, date of disposition, date of disposition, and names of staff involved. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		

Minnesota Department of Health
Food, Pools and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/14/22*
Time: 10:30:44
Report: 1002221179

Food and Beverage Establishment Inspection Report

Location:
Minnesota Greenleaf
1006 Greenwood Street East
Thief River Falls, MN56701
Pennington County, 57

Establishment Info:
ID #: 0038025
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7019369680
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

REPEAT VIOLATION FROM 6/3/21: MILK IN ARCTIC AIR COOLER WAS MEASURED TO BE GREATER THAN 41 dF.

9/14/22: MILK IN ARCTIC AIR COOLER WAS MEASURED TO BE BETWEEN 44-46 dF. ITEMS WERE DISCARDED AT TIME OF INSPECTION.

Comply By: 09/14/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

VIOLATION ISSUED ON 5/1/19: PROVIDE A THERMOMETER WITH A THIN PROBE.

Comply By: 09/21/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

REPEAT VIOLATION FROM 6/3/21: NO METHOD AVAILABLE AT TIME OF INSPECTION TO MEASURE THE UTENSIL SURFACE TEMPERATURE OF THE DISH MACHINE.

Comply By: 09/21/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO SANITIZER TEST KIT AVAILABLE AT TIME OF INSPECTION TO MEASURE THE CONCENTRATION OF THE QUARTERNARY AMMONIUM-BASED SANITIZER SOLUTION.

Comply By: 09/21/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

REPEAT VIOLATION FROM 6/3/21: THIS ESTABLISHMENT DOES NOT CURRENTLY HAVE A DESIGNATED CFPM.

Comply By: 11/14/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

REPEAT VIOLATION FROM 6/3/21: REPAIR OR REPLACE THE ARCTIC AIR COOLER TO ENSURE PROPER COLD HOLDING TEMPERATURES.

9/14/22: THERE IS VISIBLE DAMAGE TO THE DOOR/GASKET OF THIS COOLER. DISCONTINUE STORING TCS FOODS IN THIS UNIT UNTIL ISSUE IS RESOLVED.

Comply By: 10/14/22

Surface and Equipment Sanitizers

Utensil Surface Temp: = at 160 Degrees Fahrenheit
Location: THERMOLABEL - DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: DISPENSER @ 3 COMP SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: AMBIENT TEMP - AURORA FREEZER
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: AMBIENT TEMP - SATURN FREEZER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: STRAWBERRIES - WHIRLPOOL COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 43 Degrees Fahrenheit - Location: GRAPE JUICE (NON-TCS) - DANBY COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 44-46 Degrees Fahrenheit - Location: MILK - ARCTIC AIR COOLER
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: PASTA SALAD - BEV AIR COOLER
Violation Issued: No

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

Discussion:

Handwashing - fact sheet and sign provided with report

Employee illness - fact sheet, decision guide and log provided with report

Safe cleaning, sanitizing and warewashing - fact sheet and sign provided with report

Safe times and temperatures of TCS foods - fact sheet provided with report

Food safety among highly susceptible populations - fact sheet provided with report

Thermometer calibration - method and frequency

Certified food protection manager (CFPM) - fact sheet, application and course info provided with report

Note:
This establishment is storing various items in an unfinished room that is connected to the kitchen. Please note that this space may only be used to store unopened food, single use articles, etc. The establishment must also create separation in this room between the mechanical equipment and the kitchen supplies as the MN food code does not allow for food storage in mechanical rooms.

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 1002221179 of 09/14/22.

Certified Food Protection Manager: NONE

Certification Number: NONE Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Adina Castillon
Administrator

Signed: _____

Cassandra Hua
Public Health Sanitarian III
218-308-2142
Cassandra.Hua@state.mn.us

Report #: 1002221179

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	2	Date	09/14/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:44
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Minnesota Greenleaf	1006 Greenwood Street East	Thief River Falls, MN	56701	7019369680

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038025		Full		

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
	Supervision			
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	X	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	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	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:** 09/14/22

Inspector (Signature)