Electronically Delivered

August 18, 2023

Licensee
Serenity Living Care, Inc.
2300 Carver Avenue East
Maplewood, MN 55119

RE: Project Number(s) SL38782015

Dear Licensee:

On August 1, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 23, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 23, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on May 23, 2023, found not corrected at the time of the August 1, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)

The details of the violations noted at the time of this follow-up survey completed on August 1, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

We urge you to review these orders carefully. If you have questions, please contact Jill Hagen at 218-770-8646.

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

Sincerely,

Jill Hagen

Jill Hagen, Supervisor
State Rapid Response Team
Email: jill.hagen@state.mn.us
Telephone: 218-770-8646 Fax: 651-215-6894

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	R 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

(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: Project # SL38782015-1 On August 1, 2023, he Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on May 23, 2023. As a result of the revisit, the following order(s) were reissued and/or issued.	{0 000}		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: No further action required.	{0 110}		
{0 470} SS=C	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;	{0 470}		

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{0 470}	Continued From page 1 (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: No further action required.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who	{0 550}		

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{0 550}	Continued From page 2 are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action required.	{0 550}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}		

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{0 650}	Continued From page 3 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{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. This MN Requirement is not met as evidenced by: No further action required.	{0 660}		
{0 800} SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	{0 800}		

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{0 800}	Continued From page 4 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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 1, 2023, approximately from 11:45 am to 1:00 p.m., survey staff toured the home with the unlicensed personnel (ULP)-E and with the licensed assisted living director (LALD)-A (via teleconference call). During the tour, survey staff observed the following: -The window well of lower-level resident bedroom #3 had vine-type weed obstruction that did not allow the egress window to open fully when the ULP-E attempted to open the window. The LALD-A stated that he had previously cut down the weed. The ULP-E verifiied the finding as he	{0 800}		

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{0 800}	Continued From page 5 stated yes but the weed has grown back. -Near the designated smoking area on the wood deck, a charred/burned mark on the deck and a bottle of Kingsford lighter fluid that was placed behind the smoking furniture that posed ready access to all residents/visitors and a potential risk of fire. Survey staff also asked about the small charred/burned rea on the deck and the use of the lighter fluid. The LALD-A explained that the burned area on the deck was from a recent fire incident (report dated 6/19/2023) from a resident starting a portable bond fire on the deck but staff was able to put it out. He also explained that the police was called and came out, but fire department did not come out as staff was able to put out the fire. The LALD-A also stated they had confiscated everything, had staff performed daily checks, and unsure how the lighter fluid got placed on the deck and stated that the resident must of hid the lighter fluid. The LALD-A also stated that he had scheduled a meeting with the resident's case manager. The ULP-E removed and secured the lighter fluid in the garage immediately. The above findings were verbally and/or physically verified by the LALD-A (via teleconference call) and the ULP-E accompanying the house tour. On August 1, 2023, at approximately 1:15 p.m., at the during the teleconference exit interview, the LALD-A acknowledged the above findings.Survey staff explained that to the LALD-A that the licensee is responsible for the safety of residents and staff, and therefore, the licensee must develop a more stringent plan to impliment/eliminate potential risks of a fire such as lighter fluid in the smoking area after the incident. In addition, immediately after the exit	{0 800}		

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{0 800}	Continued From page 6 interview, the ULP-E showed survey staff that he just removed all the weed in the bedroom #3 window well. No further information was provided.	{0 800}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}		
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: No further action required.	{01460}		

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{01470}	Continued From page 7	{01470}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	{01470}		

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{01470}	Continued From page 8 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01470}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	{01650}		

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{01650}	Continued From page 9 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: No further action required.	{01650}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	{01940}		

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{01940}	Continued From page 10 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required.	{01940}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 9, 2023

Licensee
Serenity Living Care Inc
2300 Carver Avenue East
Maplewood, MN 55119

RE: Project Number(s) SL38782015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 23, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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).

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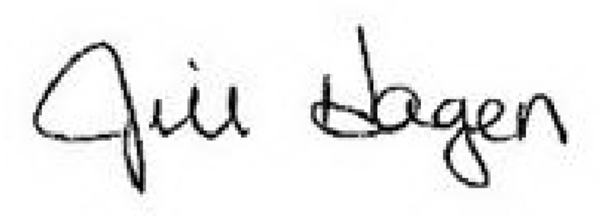
If you have any questions, please contact me.

Sincerely,



Jill Hagen, Supervisor
State Rapid Response Team
Email: jill.hagen@state.mn.us
Telephone: 218-770-8646 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL38782015-0 On May 22 and 23, 2023, 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 and investigation, there were two (2) residents receiving services under the provider's Provisional Assisted Living Facility license. An immediate correction order was identified on May 23, 2023, issued for SL38782015-0, tag identification 0820. Correction orders were issued that were not immediate, related to the survey SL38782015-0, tag identification 0110, 0460, 0470, 0480, 0550, 0650, 0660, 0780, 0790, 0800, 0810, 0970, 1460, and 1470.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on May 22, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated he was the LALD for the facility. LALD-A obtained an assisted living director license on August 10, 2021. On May 22, 2023, at 5:11 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-A held a current assisted living director license. The BELTSS website did not indicate LALD-A was listed as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 During an interview on May 23, 2023, at 12:49 p.m., LALD-A stated he was not listed as director of record on the BELTSS website. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	0 110		
0 470 SS=C	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	0 470		

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0 470	Continued From page 3 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staffing plan was posted as required. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: During the facility tour on May 22, 2023, at 1:06 p.m., the staffing schedule was not observed posted in a central location. During an interview on May 22, 2023, at 1:15 p.m., licensed assisted living director (LALD)-A stated the licensee did not have a daily staffing schedule posted in a central location. The licensee's policy titled Staffing, dated April 1, 2022, indicated the schedule was posted at the beginning of the shift in a central location accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 470		

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0 480	Continued From page 4	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 22, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 5 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's 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 potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure, including the name, telephone	0 550		

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0 550	Continued From page 6 number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was not contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or a reporting number for suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). During the facility tour on May 22, 2023, at 1:06 p.m., the above required information was not observed posted in the facility. During an interview on May 22, 2023, at 1:15 p.m., the licensed assisted living director (LALD)-A stated the licensee's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances, contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and a reporting number for suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) was not posted. The licensee's policy titled Grievance dated April 1, 2021, indicated the licensee would post in a conspicuous place, information about the grievance procedure, and the name, telephone number, and email contact information for the individuals who were responsible for handling resident complaints. The same policy indicated the posting would include contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult	0 550		

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0 550	Continued From page 7 Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 550		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all the required content for two	0 650		

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0 650	Continued From page 8 of two employees (owner (OW)-B and registered nurse (RN)-D) and all of the other licensee's employee records 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 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's Provisional Assisted Living Facility license became effective on February 23, 2022. The licensee started services for resident (R1) on February 22, 2023. During the entrance conference on May 22, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated he was aware of the required contents of employee records. OW-B's hire date was February 2020. OW-B's employee records did not include: - records of orientation, required annual training, infection control training, and competency evaluations; - signed job description During an observation on May 23, 2023, at 8:40 a.m., OW-B administered R1's morning medications. During an interview on May 23, 2023, at 11:50	0 650		

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0 650	Continued From page 9 a.m., OW-B stated RN-D provided in-person training and competency evaluations on medication administration before OW-B administered resident's medications. When asked if OW-B completed orientation prior to providing services to residents, OW-B stated she completed online training. During an interview on May 23, 2023, at 11:54 a.m., RN-D stated she went to the facility and provided in-person training and competency evaluations for all the licensee staff including medication administration. RN-D stated she did not keep record of her training and competency testing. When asked if RN-D received orientation upon hire, RN-D stated she did not. RN-D's hire date was February 22, 2022 RN-D's employee records did not include: - records of orientation, required annual training, and infection control training - signed job description During an interview on May 23, 2023, at 1:15 p.m., licensed assisted living director (LALD)-A stated no employee records at the licensee contained records of orientation, required annual training, infection control training, medication competency evaluations, or signed job descriptions. The licensee's policy titled Personnel Records dated April 1, 2022, indicated all employee record would contain: documentation of orientation, records of annual training, infection control training, competency evaluations, and signed job descriptions. No further information provided.	0 650		

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0 650	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650		
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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment. In addition, the licensee failed to ensure an employee TB history and symptom screening was completed upon hire for one of one employee (owner (OW)-B) and all the other employees with records reviewed. This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 11 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: The licensee's Provisional Assisted Living Facility license became effective on February 23, 2022. The licensee started services for resident (R1) February 22, 2023. During the entrance conference on May 22, 2023, at 11:45 a.m., the surveyor requested the licensee's facility TB risk assessment. The licensed assisted living director (LALD)-A stated the facility had not completed a TB risk assessment. During an observation on May 23, 2023, at 8:40 a.m., owner (OW)-B administered R1's morning medications. OW-B had a hire date of February 2020. OW-B's employee record did not include: -TB history and symptoms screen. -Documentation of initial and ongoing TB-related training and education. On May 22, 2023, at 2:22 p.m., LALD-A, stated the licensee did not complete a TB risk assessment, did not have a designated and documented qualified person or team with primary responsibility for the TB infection control	0 660		

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0 660	Continued From page 12 program, and none of the licensee's staff completed a TB history and symptom screening. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The TB infection control program should identify a qualified team or persons in the facility primary responsibility and authority for TB infection control. TB training was required at time of hire for all health care workers. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's policy titled Tuberculosis Screening/Prevention dated April 1, 2022, indicated the licensee would conduct a formal TB risk assessment. The same policy indicated staff would receive education regarding TB and would receive a baseline screening which includes assessing for current symptoms of active TB disease and an assessment of TB history. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		

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0 780	Continued From page 13	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm causes all alarms to actuate, sounding throughout the home. In addition, the licensee failed to provide a smoke alarm immediately outside of the lower-level bedrooms. This has the potential to directly affect the residents, visitors, and staff.	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 23, 2023, approximately from 10:40 am to 11:50 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: -The main-level hallway hardwired combination smoke and carbon monoxide alarm sounded local when the LALD-A tested the smoke alarm. The finding was evident as this smoke alarm was not the same brand as the other smoke alarms in the home. In addition, the LALD-A stated that the combination smoke/carbon monoxide alarm was hardwired and not battery-type like the other smoke alarms. -No smoke alarm installed immediately outside of the resident rooms on the lower-level hallway. The LALD-A confirmed the finding as he directed survey staff to the smoke alarm located in the common family room near the stairway. Survey staff commented that the LALD-A may relocate the living room smoke alarm to the hallway immediately outside of the resident bedrooms. -The battery-type smoke alarm inside the lower-level resident room #3 was tested by the LALD-A and the wireless feature did call the home's battery-type smoke alarms but failed to sound/alarm throughout the home for proper	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38782	A. BUILDING: _____ B. WING _____	05/23/2023

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0 780	Continued From page 15 notification. The listed findings were verbally and/or physically verified by the LALD-A accompanying the tour. On May 23, 2023, at approximately 12:30 p.m., at the exit interview, the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain monthly visual inspections on portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff.	0 790		

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0 790	Continued From page 16 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 May 23, 2023, approximately from 10:40 am to 11:50 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed the new portable fire extinguishers located on the lower-level and inside the main-level kitchen cabinet lacked records to show the monthly visual inspections. Survey staff explained to the LALD-A that the portable fire extinguishers must be provided with monthly visual inspection or "quick checks" of each extinguisher by staff to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. If extinguishers were compromised or questionable, they will need to get them to a vendor for servicing such as recharging or maintenance. The LALD-A verified the findings while accompanying the tour. On May 23, 2023, at approximately 12:30 p.m., at the exit interview, the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 790		

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0 790	Continued From page 17 (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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 May 23, 2023, approximately from 10:40 am to 11:50 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed the following:	0 800		

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0 800	Continued From page 18 -No approved smoke receptor was provided for the designated smoking area. The finding was evident as the deck was observed with a tin can with cigarette butts. -The window well of lower-level resident room #3 had thick weed obstructions that do not allow the egress window to open fully as designed. The LALD-A stated that he can cut the weed immediately. -The dining area patio door had an 8-inch sudden drop stepping into the outside deck that posed safety concerns to the residents and staff. The LALD-A agreed and verified the finding. -The lower-level exterior deck transition into the concrete walkway was not smooth nor level with the deck creating a 3-inch tripping hazard. -The wall inside resident room 2 had a doorknob penetration indent that needed to be repaired. The above findings were physically verified by the LALD-A accompanying the tour. On May 23, 2023, at approximately 12:40 p.m., at the exit interview, the LALD-A acknowledged the above findings. No further information was provided. 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;	0 810		

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0 810	Continued From page 19 (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. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan and the minimum required training of staff on the fire safety and evacuation plan. This had the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care.	0 810		

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0 810	Continued From page 20 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 May 23, 2023, approximately from 10:40 am to 11:50 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. On May 23, 2023, at approximately 11:50 a.m., survey staff reviewed the facility fire safety and evacuation plan and related documentation for review from the LALD-A. Document review and interview with the LALD-A at approximately 12:20 p.m. indicated the following: -The posted home layout plans had very small print and were not legible to read. The LALD-A verified the finding and agreed to revise the plans and include evacuation routes. -The documentation lacked fire protection procedures for residents. -The policy documentation lacked the records of employee training on the facility fire safety and evacuation plan for upon hiring of employees and at least twice per year thereafter. No records were available or provided for review. LALD-A verified the findings as he stated that they have met with employees verbally a few times for training but did not record the training. -Record review indicated two evacuation fire drills	0 810		

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0 810	Continued From page 21 were performed by employees to date, February 23, 2023, and May 3, 2023, and both drills lacked recorded time to ensure all employee shifts were covered. Survey staff explained the minimum number of required evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month, for a minimum total of six evacuation drills. On May 23, 2023, at approximately 12:40 p.m., at the exit interview, the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	0 820		

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0 820	Continued From page 22 Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide the resident bedroom window openings to meet the minimum state standard for egress. This affected the occupied resident bedrooms 1 and 4. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 23, 2023, approximately from 10:40 am to 11:50 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed and LALD-A confirmed egress windows for main-level floor bedroom 1 and the lower-level floor bedroom 4 failed to meet the minimum state standard for egress windows: -Bedroom 1: The LALD-A opened the double hung egress window in bedroom 1 (main level) and survey staff measured the egress window clear opening dimensions at a height of 15 inches and width of 21.5 inches, totaling an open clear area of 322.5 square inches which did not meet the minimum required area of 648 square inches and a minimum clear opening height of 20 inches for an egress window. -Bedroom 4: The LALD-A opened the sliding	0 820	Window replacement completed. -Bedroom 1: (main level) new egress window clear opening dimensions height of 43 inches and width of 21 inches, -Bedroom 4: New sliding egress (lower level) now measures 44 inches and width of 20.5 inches. Please see attached pictures for reference. Elvis Vuluyen, ALD Assisted Living Director Serenity Living Care Inc 2300 Carver Ave E, Maplewood, MN 55119 Cell # 651-428-8167 On May 26, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	

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0 820	Continued From page 23 egress window in bedroom 4 (lower level) and survey staff measured the egress window clear opening dimensions at a height of 45 inches and width of 17.5 inches which did not meet the minimum clear width opening of 20 inches for an egress window. Survey staff explained to the LALD-A, that at least one window in each resident bedroom (1 and 4) must meet the minimum total window clear opening area of at least 648 square inches (4.5 square feet) with at least 20 inches in height and a clear minimum width of 20 inches required for existing egress window openings for bedrooms for assisted living facilities. All listed findings were visually and/or verbally verified by the LALD-A accompanying the tour. On May 23, 2023, at approximately 12:30 p.m., at the exit interview, survey staff explained to the LALD-A that an immediate correction order was issued for the above findings and that the immediate correction order will be issued today. The LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	0 970		

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0 970	Continued From page 24 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property for one of one (R1) resident record reviewed. This had the potential to affect all the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Review of R1's medical record indicated R1 was admitted for services on February 22, 2023 R1's Assisted Living Contract was signed by R1 and the licensee on February 22, 2023. R1's Assisted Living Contract included a provision that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. On page 11 "Miscellaneous Provisions" the contract indicated: The resident shall maintain at all times his or her own health, personnel property, liability, automobile and other insurance coverage. The resident agrees that Serenity living Care is not an insurer of the resident's person or property. The	0 970		

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0 970	Continued From page 25 resident agrees that Serenity living Care will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of the resident) suffered by the resident or the resident's agents, guests, or invitees, unless and to the extent that the injury or damage is caused by the negligence of Serenity living Care or its employees or agents. The resident hereby releases Serenity living Care from liability for any personnel injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of Serenity living Care or its employees or agents. During an interview on May 23, 2023, at 9:34 a.m., the licensed assisted living director (LALD)-A stated R1's contract was the same contract in use for all the residents. LALD-A stated the licensee's contract contained a waiver of facility liability for the health, safety, and personnel property of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 970		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each	01460		

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01460	Continued From page 26 staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for two of two employees (owner (OW)-B and registered nurse (RN)-D) and all the other licensee's employees with records reviewed. This has the potential to affect all the licensee's residents. 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 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: The licensee's Provisional Assisted Living Facility license became effective on February 23, 2022. The licensee started services for resident (R1) on February 22, 2023. During an observation on May 23, 2023, at 8:40 a.m., OW-B administered R1's morning medications. OW-B OW-B had a hire date of February 2020. OW-B's employee record did not include	01460		

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01460	Continued From page 27 evidence the employee received orientation to assisted living requirements. During an interview on May 23, 2023, at 11:50 a.m., OW-B stated she completed orientation training on-line. RN-D RN-D had a hire date of February 22, 2022. RN-D's employee record did not include evidence the employee received orientation to assisted living requirements. During an interview on May 23, 2023, at 11:54 a.m., RN-D stated she did not receive orientation to assisted living licensing requirements upon hire. During an interview on May 23, 2023, at 1:15 p.m., the licensed assisted living director (LALD)-A stated OW-B, RN-D, and all other licensee employee records did not contain orientation records. The licensee's policy titled Staff Orientation and Education dated April 1, 2022, indicated upon hire and before providing services to residents all employees would receive orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01460		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	01470		

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SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

(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
01470	Continued From page 28 (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01470		

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	38782	A. BUILDING: _____ B. WING _____	05/23/2023

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SERENITY LIVING CARE INC	2300 CARVER AVENUE EAST MAPLEWOOD, MN 55119

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01470	Continued From page 29 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations with all required content for two of two employees (owner (OW)-B and registered nurse (RN)-D) and all the other licensee's employees with employee records reviewed. This had potential to affect all the licensee's residents. 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 the residents). The findings include: The licensee's Provisional Assisted Living Facility license became effective on February 23, 2022.	01470		

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01470	Continued From page 30 The licensee started services for resident (R1) on February 22, 2023. During an observation on May 23, 2023, at 8:40 a.m., OW-B administered R1's morning medications. OW-B had a hire date of February 2020. OW-B's employee record did not include evidence the employee received orientation on the following topics: - an overview of Assisted Living statutes and rules; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 31 Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee would be providing and the facility's category of licensure. RN-D had a hire date of February 22, 2022. RN-D's employees record did not include evidence the employee received orientation on the following topics: - an overview of Assisted Living statutes and rules; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470		

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01470	Continued From page 32 -a review of the types of assisted living services the employee would be providing and the facility's category of licensure. During an interview on May 23, 2023, at 11:50 a.m., OW-B stated she completed orientation prior to providing services to resident's, OW-B stated she completed online training. During an interview on May 23, 2023, at 11:54 a.m., RN-D stated she did not receive orientation to assisted living licensing requirements upon hire. During an interview on May 23, 2023, at 1:15 p.m., the licensed assisted living director (LALD)-A stated OW-B, RN-D, and all other licensee employee records did not contain orientation records. The licensee's policy titled Staff Orientation and Education dated April 1, 2022, indicated upon hire and before providing services to residents all employees would receive orientation to include: - overview of the appropriate Assisted Living statutes and rules. - introduction and review of the licensee's policies and procedures related to the provision of assisted living services. - handling of emergencies and use of emergency services. -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - the principles of person-centered planning and service delivery and how they apply to direct	01470		

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01470	Continued From page 33 support services provided by the staff person. - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the	01650		

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01650	Continued From page 34 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1) 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: During an observation on May 23, 2023, at 8:40 a.m., owner (OW)-B administered R1's morning medications and checked R1's glucose level using a glucose monitor and sensor on R1's upper arm. R1's signed service plan dated February 23,	01650		

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01650	Continued From page 35 2023, did not include: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences. During an interview on May 23, 2023, at 10:01 a.m., the licensed assisted living director (LALD)-A stated R1's service plan did not include fees for services or R1's glucose monitoring. The licensee's policy titled Service Plan dated August 1, 2021, indicated the service plan would include a description of the services to be provided, the frequency of service, and fees for the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01650		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy	01940		

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01940	Continued From page 36 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R1) with glucose monitoring. 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: R1's Assisted Living Contract was signed by R1 and the licensee on February 22, 2023.	01940		

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01940	Continued From page 37 R1's signed service plan dated February 23, 2023, did not include a written statement of glucose monitoring. During an observation on May 23, 2023, at 8:40 a.m., OW-B checked R1's glucose level using a glucose monitor and sensor on R1's upper arm. During an interview on May 23, 2023, at 10:01 a.m., the licensed assisted living director (LALD)-A stated R1's service plan did not include a statement of glucose monitoring. The licensee's policy titled Treatment and Therapy Management dated April 1, 2022, indicated the RN or licensed professional would prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy's which addresses the type of service to provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/22/23*
Time: 12:00:00
Report: 1025231127

Food and Beverage Establishment Inspection Report

Location:
Serenity Living Care Inc
2300 Carver Ave E
Maplewood, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0041262
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
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.

Potato salad in refrigerator at 44 deg F; milk at 49 deg F. Maintain all cold TCS foods at or below 41 deg F. Adjusted during inspection.

Comply By: 05/22/23

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

Open container/plastic of deli roast beef in the refrigerator date labeled properly, but labeled from 4/27. Discard TCS foods opened after 7 days.

Comply By: 05/22/23

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.

Provide a thermometer as indicated above for the ktichen.

Comply By: 05/26/23

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.

Provide a means of testing the internal contact temperature in the dishwasher.

Comply By: 05/26/23

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Both sink basins contained utensils - dedicate one basin to handwashing only.

Comply By: 05/22/23

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

SINK USAGE
Facility has one large basin sink and a small side sink
Dedicate one sink basin exclusively to handwashing (signage provided)
Suggest the small side sink
Facility does not have a dedicated food preparation sink

DISHWASHING
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing
Recommend having an alternative means of sanitizing available case of emergency or service interruption

COUNTERTOPS AND FOOD CONTACT SURFACES
Facility has laminate counterstops
Provide a smooth, non-porous food contact surface (e.g. cutting board) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher).
Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean but without the use of chemicals which may damage the finish. Do not use wood as a food contact surface.

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if

approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

CFPM
For information, please search "MDH CFPM"

GENERAL COMMENTS
Discussed employee health and hygiene, illness exclusion
Food cook and holding temperatures, cross-contamination
Highly susceptible populations - no service or raw or undercooked animal food
Provide a food thermometer with a thin-probe (e.g. a digital thermometer with the thin tip)
Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days)
Chemical label, use, and storage, reported no food stored outside of the kitchen on-site
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse.
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

ADDITIONAL INFORMATION

"MDH Highly Susceptible Population"
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf
"MDH TCS Foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/tcsfoodfs.pdf
"MDH Sanitizing"
https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf

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 1025231127 of 05/22/23.

Certified Food Protection Manager: Rebecca Vuluyen

Certification Number: FM115901 Expires: 03/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231127

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	3	Date	05/22/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Serenity Living Care Inc	Address: 2300 Carver Ave E	City/State: Maplewood, MN	Zip Code: 55109	Telephone
License/Permit #: 0041262	**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

		Safe Food and Water	COS	R
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		

		Proper Use of Utensils	COS	R
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	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:** 05/22/23

Inspector (Signature) Cory King