DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 15, 2023

Licensee
Stonebay Senior Living
2635 Kelly Parkway
Orono, MN 55356

RE: Project Number(s) SL36734015

Dear Licensee:

On June 14, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 29, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

PMB

Electronically Delivered

April 13, 2023

Licensee
Stonebay Senior Living
2635 Kelly Parkway
Orono, MN 55356

RE: Project Number(s) SL36734015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted no violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents no violations. The Department of Health documents the state licensing correction orders using federal software. Please disregard the heading of the fourth column that states, "Provider's Plan of Correction." A plan of correction is not required.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000

The total amount you are assessed is $3,500. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email 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

REQUESTING A HEARING

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: Fax: 651-281-9796

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

(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: SL36734015-0 On March 27, 2023 through March 29, 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, there were 52 active residents; 28 receiving services under the Assisted Living Dementia Care license. An immediate correction order was identified on March 27, 2023, issued for SL36734015-0, tag identification 1290. On March 28, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1	0 510		

maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.
(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.
(c) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control for all of 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) 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:

HAND HYGIENE
On March 28, 2023, from 7:15 a.m. through 7:30 a.m., the evaluator observed unlicensed personnel (ULP)-B enter resident (R6)'s room without preforming hand hygiene. ULP-B donned clean gloves and prepared and administered medications for R6, then removed gloves and

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0 510	Continued From page 2 preformed hand hygiene. On March 28, 2023, from 7:38 a.m. through 7:54 a.m., the evaluator observed ULP-B deliver a meal tray to R6 and obtain R6's oxygen saturation and pulse. Without preforming hand hygiene ULP-B delivered a meal tray to R8, then went to R9's room, and without preforming hand hygiene, donned clean gloves. ULP-B prepared and administered medications to R9 and then removed gloves and preformed hand hygiene. DISINFECTING EQUIPMENT ULP-B ULP-B had a hire date of February 23, 2021. On March 28, 2023, from 7:00 a.m. until 7:54 a.m., the evaluator observed ULP-B obtain oxygen saturations and pulses for four residents with a community oximeter probe. ULP-B failed to disinfect the oximeter probe between residents. ULP-F ULP-F had a hire date of December 26, 2022. On March 28, 2023, at approximately 7:40 a.m., the evaluator observed ULP-F remove R5's oxygen therapy nasal cannula with tubing for breakfast, and the nasal cannula with tubing fell on the dining room floor. ULP-F then proceeded to coil up R5's oxygen tubing for storage, and as the tubing was being coiled up, the attached nasal cannula dragged on the floor. ULP-F failed to perform cleaning or replacement of R5's oxygen nasal cannula that fell on the floor. On March 28, 2023, at 8:06 a.m., clinical nurse supervisor (CNS)-D stated staff were trained to wash hands between each resident after whenever hands are physically soiled and after	0 510		

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0 510	Continued From page 3 changing gloves, and they should always disinfect equipment between each resident. On March 28, 2023, at approximately 11:05 a.m., CNS-D indicated that oxygen tubing changes varied per resident, and cleaning of oxygen tubing and nasal cannulas occur as needed. The licensee's undated Disinfecting Reusable Equipment policy indicated after using reusable equipment, the equipment must be cleaned and returned to the place it is stored. The licensee's undated Handwashing policy indicated hand washing shall be performed between client caress and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: 1. Before and after direct contact with a client 2. If moving from a contaminated-body site to a clean-body site during client care 3. After contact with environmental surfaces or equipment in the immediate vicinity of the client 4. After removing gloves or gown 5. Before eating and after using a restroom. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 4	0 630		

person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) with required content for all identified independent living 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) 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:

R2 signed the licensee's Resident Agreement on January 5, 2022.

R2's record lacked an IAPP developed and implemented by the licensee.

On March 27, 2023, at 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-C provided the licensee's Current Resident Roster - Assisted Living form which listed all residents who resided at the facility. There were 24 residents who were identified as

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0 630	Continued From page 5 not receiving services (commonly referred to as independent living) and were identified by an "X," in the column labeled, "Housing Only". On March 27, 2023, at approximately 12:42 p.m., LALD-C indicated the licensee had just started the process to develop and implement an IAPP for residents who were identified as independent living and intended to complete them within a week. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 6	0 680		

received emergency and disaster training are allowed to work only when trained staff are also working on site.
(c) The facility must meet any additional requirements adopted in rule.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On March 27, 2023, at approximately 11:05 a.m., licensed assisted living director (LALD)-C provided a binder and indicated the contents were the licensee's EP plan.

The licensee's undated EP plan lacked:
-risk assessment;
- development of EP policies and procedures based on risk assessment;
-documentation of annual review;
-documentation of missing resident quarterly review;
-patient population needs;
-EP collaboration;
-policies and procedures for medical documents,

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0 680	Continued From page 7 volunteers, arrangement with other facilities, roles under a waiver declared by secretary, alternate means for communication, and methods for sharing information; and -emergency testing as required per Appendix Z. On March 27, 2023, at approximately 11:35 p.m., LALD-C acknowledged the licensee's emergency preparedness plan lacked the above listed required content, and was not aware of the required content of Appendix Z. The licensee's undated Emergency Preparedness Manual policy indicated the licensee's EP would include all required elements of Appendix Z. Additionally, the plan would be in writing and reviewed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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,	0 800		

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0 800	Continued From page 8 including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. 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). Findings include: On March 29, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-C. During the facility tour, survey staff observed the following items: In resident unit 201 and the activity room on the second floor, it was observed that brown stains were on the sheetrock ceiling with evidence of water damage. During the interview, LALD-C stated that there was roofing leakage above the unit, and he was working with a contractor to repair it. In resident unit 109, it was observed that brown stains were on the sheetrock ceiling with evidence of water damage. LALD-C visually verified these deficient findings at the time of discovery.	0 800		

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0 810	Continued From page 9	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (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:	0 810		

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0 810	Continued From page 10 Based interview and record review, the licensee failed to develop and maintain a fire safety and evacuation plan that shows the number and location of resident rooms, failed to shows procedures for movement, evacuation, or relocation including identification of unique or unusual resident needs; and failed to complete employee evacuation drills every other month. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 29, 2023, at approximately 10:00 a.m. with the Licensed Assisted Living Director (LALD)- C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of available documentation indicated that the fire safety and evacuation plan did not show the location and number of resident rooms. Record review of the available documentation that the fire safety and evacuation plan did not have procedures for resident movement, evacuation, or relocation during a fire or similar emergency, including the identification of unique	0 810		

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0 810	Continued From page 11 or unusual resident needs for movement or evacuation. During the interview, LALD-C stated that the licensee did not have anything in the fire safety and evacuation plan that prescribed any different measures or that provided identification of the unique needs of residents for movement or evacuation. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During the interview, LALD-C verified that there were no further documented drills for the facility other than what was provided and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to	0 970		

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0 970	Continued From page 12 affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 27, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C provided the evaluator with a blank Assisted Living Contract and Resident handbook. The contract included the following sectios: - Loss or Damage to Property: The community shall not be responsible for any loss or damage to any valuables, personal effects, or money brought into the community by the resident, including but not limited to, dentures, hearing aids, and eyeglasses. The handbook included the following sections: - Vehicle: You release the community, its associates, members and agents of any responsibility or liability for loss and/or damages to your vehicle, including but not limited to theft, collision, fire, acts of God, weather, construction, etc. - Insurance (Personal Property & Liability): The community is not responsible for the loss or damages of personal belongings. On March 29, 2022, at 1:15 p.m., LALD-C stated the licensee used the contract and handbook for all residents who received services. LALD-C also stated they believed the liability had been removed from the contract, but they [licensee]	0 970		

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0 970	Continued From page 13 must have missed it in the handbook. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was conducted prior to staff providing services for one of three employees (unlicensed personnel (ULP)-B). 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	01290	On March 28, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained and the scope and level remain unchanged.	

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01290	Continued From page 14 issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired February 23, 2021. ULP-B's record included Department of Human Services Background Study Clearance letter dated February 28, 2021, associated with an unrelated licensee with a Health Facility Identification (HFID) license number 22195. The licensee's Scheduling Template dated March 20, 2023, through April 2, 2023, indicated ULP-B was scheduled to work 7:00 a.m. to 7:00 p.m., on March 20, March 24, March 27, and March 28, 2023. ULP-B's employee record lacked evidence of a current, cleared BGS affiliated with the licensee's assisted living with dementia care HFID license number 36734, effective August 1, 2021. On March 27, 2023, at 2:45 p.m., licensed assisted living director (LALD)-C stated, "I went thru and printed everything, and I think that was the only background test. So, we have never run it." The licensee's undated Reference and Background Checks policy, indicated the licensee would complete background checks prior to the first day of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01290	Continued From page 15 On March 28, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained and the scope and level remain unchanged.	01290		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R3) with insulin administration and failed to ensure medications were transcribed and administered as prescribed for one of three residents (R3) observed during medication administration. 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	01760		

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01760	Continued From page 16	01760		

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:

INSULIN ADMINISTRATION
R3 was admitted to the licensee February 2, 2021, and started receiving assisted living services August 1, 2021.

R3's Service Plan dated March 27, 2023, indicated R3 received medication administration.

R3's diagnoses included myocardial infarct [heart attack], bilateral lower extremity edema, diastolic congestive heart failure, atrial fibrillation, and Diabetes Mellites type 2.

R3's provider order dated February 3, 2023, included Lantus Solostar (an injectable medication for diabetes) 35 units daily.

On March 28, 2023, at 7:04 a.m., the evaluator observed unlicensed personnel (ULP)-B administer 35 units of insulin to R3's lower left abdomen without priming the insulin pen with two units prior to dialing to the prescribed dose. ULP-B verified they did not prime the insulin pen. ULP-B stated they were trained to eject the two units by clinical nurse supervisor (CNS)-D but, " I forgot to do that, I usually do that [prime the pen] though"."

On March 28, 2023, at 8:34 a.m., CNS-D confirmed the staff should dial the insulin pen to two units, eject the two units, and then dial the insulin pen to the prescribed dose.

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The manufacturer's instruction for Lantus Solostar dated August 2022 instructed to prime the pen before each injection, by dialing a test dose of two units, tapping the cartridge holder gently to collect air bubbles at the top, and pushing the injection button all the way in and check to see that insulin comes out of the needle and the dial returns to zero.

The licensee's undated Administration of Insulin policy indicated the care provider must dial up two units to prime the pen and discard it with each administration of insulin.

TRANSCRIPTION ERROR
R3's electronically signed medication order dated March 20, 2023, indicated lidocaine patch 5 percent (%) to low back for chronic pain. Apply one patch to lower back 12 hours per day.

R3's Med Admin Summary dated March 1, 2023, to March 31, 2023, lacked the above medication.

On March 29, 2023, at 11:40 a.m., CNS-D stated the order was never processed and stated, "that was an error on my part, I usually verify an order, send it to pharmacy and process the order and follow it through until we receive the medication. I missed this order and never processed it."

The licensee's undated Implementation of Medication Orders policy indicated upon receipt of an order from an authorized prescriber, the licensed nurse or employee of the licensee must take action to implement the order within 24 hours, unless on a weekend when family will be responsible for medication order changes until the next tour of duty of the RN.

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01760	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 27, 2023, from 1:33 p.m. to 1:46 p.m., the evaluator observed the following in the second-floor nurses' office that was left unattended and unsecured with the office door	01880		

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01880	Continued From page 19 propped open with a door stopper: - 19 Lantus pens, - 37 NovoLog pens, - three unopened bottles of Eliquis 5 milligrams (mg) 3 bottles, - 180 capsules MAPAP 600mg, - 56 tablets Senokot -s 50mg-8.6mg, - eight tablets amlodipine 10 mg, - one unopened 16-ounce bottle of Pepto-Bismol, - 30 tablets of diphenhydramine HCl 25 mg, - three tablets of potassium 99 mg, - 16 tablets of over the counter (OTC) anti-diarrheal 2 mg, - 30 tablets of loratadine 10mg, - one unopened bottle of Tylenol 500mg containing 100 capsules, - one bottle of nystatin powder, - one bottle of colestipol hydrochloride 1gram (g), - ketoconazole 2 percent (%), - one bottle 250mg/5ml gabapentin, - one tube of Proctosol 2.5% cream, - one container of diclofenac sodium gel, - one container of Lidex 0.05% cream, - one bottle of Tylenol 500mg, - one bottle of AREDS2, - one bottle of refresh eye drops, - one bottle antacids, - one bottle hemp gummy bears 10,000,000mg, - one bottle melatonin 5mg, - one bottle Tylenol 325mg, and - one tube OTC 2 ounces neuropathy max strength cream. On March 27, 2023, from 1:33 p.m. to 1:46 p.m., the evaluator observed two residents and one visitor pass by the nurse's office and three staff enter the nurses' office.	01880		

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01880	Continued From page 20 On March 27, 2023, clinical nurse supervisor (CNS)-D stated, "The door is supposed to remain shut and locked but sometimes the staff forget to pull it shut." The licensee's undated Central Storage of Medications policy read, "when the RN has identified that a resident needs central storage of medications, that resident's medications will be stored in a clearly labeled, locked cabinet in registered nurse office/medication room, both over-the-counter and legend drugs will be stored in this manner. Legend drugs are defined as those that cannot be dispensed without a prescription." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in	01910		

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01910	Continued From page 21	01910		

the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition for two of two discharged residents (R1, R10).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

R1
R1 discharged from the licensee on February 28, 2023.

R1's Discharge - Transfer Summary included a medication list that included aspirin 81 milligram (mg), atorvastatin 20mg, divalproex 125mg, folic acid 1mg, Jantoven 5mg, melatonin 3mg, metoprolol tartrate 25mg, naltrexone hydrochloride 50mg, quetiapine 100mg, quetiapine 25mg, senna 8.6mg, sertraline 50mg,

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01910	Continued From page 22 and vitamin b1 100mg. R2's Discharge - Transfer Summary included a handwritten note that read "[name] RN gave meds to family." R10 R10 discharged from the licensee on February 11, 2023. R10's Discharge - Transfer Summary included a medication list that included Ativan 0.5mg, Eucerin cream, haloperidol 0.5mg, morphine soltab 5mg, scopolamine 1mg/3-day patch, bisocodyl 10mg, hydrocortisone cream 1 percent (%), and hyoscyamine 0.125mg. R10's Discharge - Transfer Summary included a handwritten note that read "Med destroyed med Rx with [name]/[name] LPN" On March 29, 2023, at 11:40 a.m., clinical nurse supervisor (CNS)-D stated, "A nurse will destroy the meds and we will have a second verify. They should write down the info of what is being destroyed with the dose and the amount destroyed." The licensee's undated Disposition of Medication policy indicated current medications belonging to a resident will be given to the resident or the resident's responsible person, when the resident is discharged or moves from the building, and staff will document on the medication disposition/disposal form to whom the medications were given, the time and date and the name of each medication. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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01950	Continued From page 23	01950		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R5) who had an ordered treatment. 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	01950		

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01950	Continued From page 24 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 28, 2023, at approximately 7:40 a.m., the evaluator observed unlicensed personnel (ULP)-F removed R5's oxygen therapy nasal cannula with tubing for breakfast, and the nasal cannula and tubing fell on the dining room floor. ULP-F then proceeded to coil up R5's oxygen tubing for storage, and as the tubing was being coiled up, the attached nasal cannula dragged on the floor. R5 was admitted on June 22, 2022. R5's diagnoses included congestive heart failure, atrial fibrillation, and chronic obstructive lung disease. R5's Assessment dated January 10, 2023, read under section Respiratory Function - "resident has history of COPD, resident wears oxygen". R5's physician's order signed January 10, 2023, by R5's provider read, "Oxygen 1-3 liters to keep sat above 88%". R5's record lacked a treatment plan with specified, in writing, RN specific instructions to the unlicensed personnel in the proper methods on oxygen tubing cleaning, storage, and replacement, with respect to individual needs of the resident and documented the unlicensed personnel has demonstrated the ability to competently follow the procedures. On March 28, 2023, at approximately 11:05 a.m.,	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

(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
01950	Continued From page 25 clinical nurse supervisor (CNS)-D indicated they were not sure why ULPs had not been provided specific instructions for R5's oxygen treatment but they [CNS-D] will work on providing them. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated a treatment plan with all required content would be developed and implemented for all ordered or prescribed treatments and therapy services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property	02040		

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	36734	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02040	Continued From page 26 for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of the available documentation and an interview was conducted on March 29, 2023, at approximately 10:00 a.m. with the Licensed Assisted Living Director (LALD)- C on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During the interview, LALD-C stated that the Maintenance personnel was on vacation and did not know if the hazard vulnerability assessment was performed on or around the property. LALD-C did not have further documentation to provide on the hazard vulnerability assessment hazard vulnerability assessment with mitigation factors. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=C	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 27 (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02170		

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	36734	A. BUILDING: _____ B. WING _____	03/29/2023

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02170	Continued From page 28	02170		

licensee failed to provide a selection of daily structured and non-structured activities based on individualized activity plan for two of four residents (R4, R5).

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:

R4
R4 was admitted on July 8, 2021.

R4's record included an individualized activity plan that identified R4's favorite wellness activities as drawing or painting, cooking, scrapbooking, piano, and exercise class.

R5
R5 was admitted on July 31, 2022.

R5's record included an individualized activity plan that identified R5's favorite wellness activities as baking, films, bingo, socials, and Tai Chi.

On March 28, 2023, at approximately 10:00 a.m., life enrichment director (AD)-G provided a piece of paper labeled Activities Weekly Calendar MC dated March 27 - 31, and indicated the paper were the licensee's current activity schedule for memory care. The licensee's memory care activity schedule indicated activities scheduled Monday through Friday from 10:00 a.m. to 3:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 29 p.m., with no activities scheduled for Saturday and Sunday. On March 28, 2023, at approximately 10:45 a.m., AD-G indicated R4's and R5's activities evaluation had been completed, however the licensee failed to provide a selection of weekend structured activities for R4, R5, or any memory care resident residing in the facility. The licensee's Activity Calendar policy undated, indicated the facility will provide a selection of daily unstructured and unstructured activities on Saturday and Sunday as part of the resident's activity service or care plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *04/10/23*
Time: 13:50:39
Report: 7994231078

Food and Beverage Establishment Inspection Report

Location:
Stonebay Senior Living
2635 Kelley Parkway
Orono, MN55356
Olmsted County, 55

Establishment Info:
ID #: 0037636
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522000585
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.

No NEW orders were issued during this inspection.

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

THIS WAS AN ANNOUNCED INSPECTION AS PART OF A HRD SURVEY. I SPOKE WITH THE PERSON IN CHARGE ABOUT THIS REPORT AND ANY ITEMS WITHIN.

TEMPERATURES:
TOMATOES 38
CHICKEN 38
SLICED MEATS 40
PIE 39

SHEPARDS PIE 143

SANITIZERS:
DISHWASHER 169 F

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994231078 of 04/10/23.

Certified Food Protection Manager: Robert Kutscher

Certification Number: 75847 Expires: 03/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva

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

Report #: 7994231078

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	0	**Date**	04/10/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	13:50:39
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Stonebay Senior Living	2635 Kelley Parkway	Orono, MN	55356	9522000585

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0037636		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 04/10/23

Inspector (Signature) Crystal Elva