Electronically Delivered

October 16, 2025

Licensee
Family Tree Care Homes
2029 Palmer Drive
New Brighton, MN 55112

RE: Project Number(s) SL33728016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

(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: SL33728016-0 On September 8, 2025, through September 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility with Dementia Care license.	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.	
0 650 SS=F	144G.42 Subd. 8 (a) Staff records	0 650		

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0 650	Continued From page 1 (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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 interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies for one of one employee (unlicensed personnel (ULP)-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. 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	0 650		

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0 650	Continued From page 2 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: ULP-B was hired on September 26, 2022. ULP-B's personnel record lacked documentation of training and competency evaluation related to medication administration when a licensed nurse was not available to provide medications for a resident with an unplanned time away from home. On September 9, 2025, at 1:09 p.m., clinical nurse supervisor (CNS)-D stated they provided verbal training and had staff return demonstration for unplanned time away but did not document the training. CNS-D stated they did not realize there was a specific need to document that training. On September 10, 2025, at 9:35 a.m., ULP-B stated their job duties included medication administration. ULP-B stated the nurse had been trained them on what to do when a resident had an unplanned time away. The licensee's Delegation of Medication to be Given to Clients by Unlicensed Staff for Clients Time Away From Home policy dated February 15, 2024, indicated only unlicensed staff that had been trained and had demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in	0 650		

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0 650	Continued From page 3 the appropriate container for an unplanned leave of absence not to exceed seven days of medications. The licensee's Personnel Records policy dated February 15, 2024, indicated the personnel record would include all required training and competency evaluations for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680		

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0 680	Continued From page 4 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Disaster Preparedness Plan, Creation & Review Log, indicated the licensee had initially adopted their EPP on July 3, 2023, and had reviewed their EPP on February 14, 2024, and April 29, 2025. The licensee lacked documentation of quarterly review of their missing person policy. The licensee's undated EPP lacked evidence of the following required content: - procedures for tracking of staff; - policies and procedures for medical documents; - roles under a waiver declared by secretary; - methods for sharing information; - sharing information on occupancy/needs; and	0 680		

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0 680	Continued From page 5 - LTC Family Notifications. On September 8, 2025, at 1:48 p.m., licensed assisted living director (LALD)-C stated the licensee needed to work on the EPP as they were recently cited at another facility owned by the licensee and had planned to work on the missing content with a consultant. On September 8, 2025, at 1:53 p.m., LALD-C stated they thought the missing person review was annually and had confirmed the licensee had not reviewed the missing person policy quarterly. The licensee's undated Emergency & Disaster Plan Policy indicated a written emergency and disaster plan would be established to meet the health, safety, and security needs of the staff and residents during an emergency or disaster. The policy did not include the required content of a written emergency and disaster plan; and did not reference or indicate it would follow the Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix Z as required in Minnesota Administrative Rule 4659.0100. Minnesota Administrative Rule 4659.0100, A., indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, sections 483.73, or successor requirements. Minnesota Administrative Rule 4659.0110, subpart 4, indicated the assisted living director and clinical nurse supervisor must review the missing resident plan at least quarterly and document any changed to the plan.	0 680		

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0 680	Continued From page 6 No additional information was 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, 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 the potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 7 The findings include: On September 9, 2025, at approximately 10:00 a.m., survey staff toured the facility with licensed assited living director (LALD)-C. The following was observed. GENERAL MAINTENANCE: The ceiling in the garage had a small area removed. LALD-C stated he wants to install a new bath fan and cut the hole to verify what was in that attic area. On September 9, 2025, LALD-C stated they would patch the removed area. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 8 (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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 9 On September 9, 2025, licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On September 9, 2025, LALD-C stated they understood the need for this policy to be in place and would develop a policy. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-C stated they train staff with Educare during orientation and do not offer facility specific training to staff twice per year. No other training documentation was provided. On September 9, 2025, LALD-C stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 10 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R2, R3) with bed rails. 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: R2 On September 8, 2025, at 11:17 a.m., during a tour of the facility, the surveyor observed room 2 where R2's bed was located. R2 had a hospital style bed with upper bilateral side rails. The surveyor grabbed the side rails and observed the side rails were not loose. R2 was admitted to the licensee on May 31, 2021, with a diagnosis of dementia. R2's [licensee] Service Plan dated June 18,	02310		

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02310	Continued From page 11 2023, indicated R2 received assisted living services that included medication set up and assistance with activities of daily living (ADLs). R2's Restraint/Entrapment Assessment dated August 20, 2023, indicated the side rail measurement for zone one was less than 4.75, zone two was "Na", zone three was less than 4, and zone four was "Na." The subsequent assessments completed on November 18, 2023, February 16, 2024, May 14, 2024, August 12, 2024, and November 10, 2024, lacked documentation of measurements of the entrapment zones. R2's Restraint/Entrapment Assessment dated February 8, 2025, indicated the side rail measurement for zone one was less than 4.75, zone two was "Na", zone three was less than 4, and zone four was "Na." The subsequent assessments completed on May 2, 2025, and August 2, 2025, lacked documentation of measurements of the entrapment zones. R3 On September 8, 2025, at 11:17 a.m., during a tour of the facility, the surveyor observed room 4 where R3's bed was located. R3 had a hospital style bed with upper bilateral side rails. The surveyor grabbed the side rails and observed the side rails were not loose. R3 was admitted to the licensee on December 17, 2022, with a diagnosis of dementia. R3's [licensee] Service Plan dated December 14, 2022, indicated R3 received assisted living services that included medication set up and assistance with activities of daily living (ADLs).	02310		

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FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

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02310	Continued From page 12 R3's Restraint/Entrapment Assessment dated August 22, 2024, indicated the side rail measurement for zone one was 3 and 5/8th longest, zone two was "Na", zone three was "Na" and zone four was "Na." The subsequent assessments completed on October 14, 2024, January 11, 2025, April 9, 2025, and July 5, 2025, lacked documentation of measurements of the entrapment zones. On September 9, 2025, at 2:15 p.m., clinical nurse supervisor (CNS)-D stated R3 had a consumer bed rail in the past but had received a hospital bed upon hospice admission. CNS-D confirmed R3's assessment completed on August 22, 2024, and beyond were of R3's hospital style bed with side rails. CNS-D stated they were aware of the need to document a bed rail assessment but thought they could just indicate no change on subsequent assessments. CNS-D was not aware of the need to document the actual measurement for each entrapment zone with each assessment. The surveyor reviewed potential zones of entrapment per the Food and Drug Administration (FDA) guidance with CNS-D. CNS-D stated they did not realize the zone descriptions of the areas that were needed to be measured as they just referenced a picture of the zones provided by the FDA. The licensee's Devices and Device Assessment policy dated February 15, 2024, indicated physical devices included side rails; and the device would be installed per FDA guidelines. The policy indicated documentation would be entered into the resident record to include results of the assessment; discussion with resident/responsible party regarding risks and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33728	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES	2029 PALMER DRIVE NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 13 benefits and alternatives considered or recommended; and decision made/outcome of discussion. Also, the policy indicated the device would be assessed for safety during each RN re-assessment. The FDA's Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, revised March 10, 2006, on page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. Also, on page 27, Appendix E, indicated drawings of potential entrapment in hospital beds. According to The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) website accessed on September 10, 2025, at 2:59 p.m., indicated under Hospital-style bed rails, the licensee must ensure the bed rail measurements were documented; the bed rail had not shifted; and the bed rail was securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

FAMILY TREE CARE HOMES
2029 PALMER DRIVE
New Brighton, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 33728

Risk:
License:
Expires on:
CFPM: Lee James Panzer
CFPM #: 52649; Exp: 2/28/2028

Inspection Info

Report Number: F1025251136
Inspection Type: Full - Single
Date: 9/8/2025 Time: 1:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

TCS foods in upright refrigerator 43 deg F - plain water put into refrigerator, take a temperature with the available TMD and adjust refrigerator if needed.
Irreversible TMD for dish machine reported used - do not use any heated dry when testing
Downstairs freezer - OK

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1025251136 from 9/8/2025

Lee James Panzer

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

FAMILY TREE CARE HOMES
New Brighton
County/Group: Ramsey County

Inspection Info

Report Number: F1025251136
Inspection Type: Full
Date: 9/8/2025
Time: 1:00 PM

New Record: **Product/Item/Unit:** Ambient**; Temperature Process:** Cold-Holding
Location: Refrigerator at 43 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** Pasta**; Temperature Process:** Hot-Holding
Location: Stovetop at 140 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

FAMILY TREE CARE HOMES
New Brighton
County/Group: Ramsey County

Inspection Info

Report Number: F1025251136
Inspection Type: Full
Date: 9/8/2025
Time: 1:00 PM

New Record: **Product:** Chlorine**; Sanitizing Process:**
Location: Spray bottle **Equal To**
Comment: 50 PPM
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1025251136

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	0	Date: 9/8/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 1:00 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
FAMILY TREE CARE HOMES	2029 PALMER DRIVE	New Brighton, MN	55112	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 33728		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions 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" or OUT 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	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
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 and used		
46		Gloves used properly		
		Utensils, 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 and plan review		

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date: