



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 3, 2025

Licensee
Willows Landing Senior Living
9872 Hart Boulevard
Monticello, MN 55362

RE: Project Number(s) SL37633016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 24, 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:

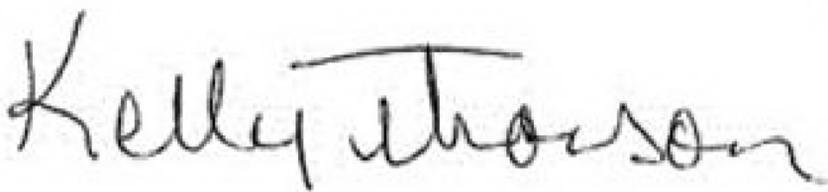
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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,



Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2025
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NAME OF PROVIDER OR SUPPLIER WILLOWS LANDING SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 9872 HART BLVD. MONTICELLO, MN 55362
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0 000	<p>Initial Comments</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL37633016-0</p> <p>On January 21, 2025, through January 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 86 resident(s); 58 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 470	Continued From page 1	0 470		
0 470 SS=F	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <ul style="list-style-type: none"> (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <ul style="list-style-type: none"> (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was posted in a central location as required. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a</p>	0 470		

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0 470	<p>Continued From page 2</p> <p>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On January 21, 2025, at 11:52 a.m., during a tour of the facility, the surveyor observed a daily and weekly staffing schedule next to the employee time clock in the employee breakroom.</p> <p>On January 21, 2025, at 11:57 a.m., DON-A stated the daily staffing scheduled is posted next to the employee time clock in the breakroom. DON-A further stated the licensee is determining a place to post the schedule near the concierge desk however denied a public posting currently.</p> <p>The licensee's 4.16 Staffing & Scheduling policy dated August 1, 2021, indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not</p>	0 470		

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0 470	Continued From page 3 disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a	0 480		

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0 480	<p>Continued From page 4</p> <p>manner that prevents contamination before storage;</p> <p>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;</p> <p>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;</p> <p>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and</p> <p>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p>	0 480		

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0 480	Continued From page 5 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current	0 660		

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0 660	<p>Continued From page 6</p> <p>guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a current facility TB risk assessment.</p> <p>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).</p> <p>The findings include:</p> <p>On January 21, 2025, at 3:31 p.m., regional nurse specialist (RNS)-G provided the surveyor with the licensee's tuberculosis (TB) risk assessment completed on January 21, 2025, dated after the survey had started. The last TB assessment completed prior to the start of survey was completed on December 11, 2023, indicating more than one year had passed between assessments.</p> <p>On January 22, 2025, at 10:53 a.m., vice president of operations (VPO)-B stated they were aware the TB risk assessment needed to be completed annually and they could not speak to why it was completed a month late.</p> <p>The licensee's 8.14 Tuberculosis Screening policy dated September 25, 2022, indicated the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health.</p> <p>The Minnesota Department of Health guidelines</p>	0 660		

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0 660	<p>Continued From page 7</p> <p>Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements:</p> <p>(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;</p> <p>(2) post an emergency disaster plan prominently;</p> <p>(3) provide building emergency exit diagrams to all residents;</p> <p>(4) post emergency exit diagrams on each floor; and</p> <p>(5) have a written policy and procedure regarding missing residents.</p> <p>(b) The facility must provide emergency and</p>	0 680		

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0 680	<p>Continued From page 8</p> <p>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 allowed to work only when trained staff are also working on site.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. In addition, the licensee failed to review the missing resident policy at least quarterly. This had the potential to affect all residents, staff, and visitors of the facility.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's EPP lacked the following content to address:</p> <ul style="list-style-type: none"> - policy/ procedure for volunteers; - policy/ procedure for roles under a waiver declared by the secretary (1135 waiver); and - missing resident plan that was reviewed quarterly. <p>On January 23, 2025, at 9:19 a.m., vice president</p>	0 680		

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0 680	<p>Continued From page 9</p> <p>of operations (VPO)-B stated that the 1135 waiver and volunteer policy were not present in EPP prior to survey started because "the 1135 waiver specifically states it is for Medicare, Medicaid, and CHIP. Which would not apply to [the facility]."</p> <p>The licensee's 9.01 Emergency Preparedness Plan- Appendix Z Compliance policy dated August 1, 2021, indicated [licensee] emergency preparedness plan will include all required elements of appendix Z.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the LALD and clinical nurse supervisor (CNS) must review the missing resident plan at least quarterly and document any changes to the plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		

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0 775	Continued From page 10	0 775		
0 775 SS=F	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient condition has the ability to affect all staff and residents.</p> <p>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).</p> <p>Findings include:</p> <p>On facility tour with the maintenance coordinator (MC)-C on January 22, 2025, between 8:00 a.m. and 12:30 p.m. the following deficient conditions were observed:</p> <p>FIRE RATED DOOR:</p> <p>The surveyor observed that the fire rated door to the kitchen was propped opened.</p> <p>The surveyor explained to the MC-C that the door to the kitchen is fire rated.</p> <p>KITCHEN COOKING EQUIPMENT:</p>	0 775		

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0 775	<p>Continued From page 11</p> <p>The surveyor observed that the cables to the moveable gas supplied kitchen equipment were not connected to the wall.</p> <p>The surveyor explained to the MC-C these restraint cables shall be connected all the time to keep the gas lines from being damaged if moved.</p> <p>EXTENSION CORD:</p> <p>The surveyor observed that a black extension cord was being used feeding a refrigerator in storage room 2nd floor.</p> <p>The surveyor explained to the MC-C extension cords cannot be used for permanent use.</p> <p>ELECTRICAL PANEL:</p> <p>The surveyor observed an open space in the P1B electrical panel.</p> <p>The surveyor explained to the MC-C that the open spaces in this panel shall be covered.</p> <p>DEMENTIA CARE AREA:</p> <p>The surveyor observed there was not an egress control locking system having the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock.</p> <p>The surveyor explained to MC-C that a compliant signal or switch shall be installed.</p> <p>EXIT DOOR:</p>	0 775		

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0 775	<p>Continued From page 12</p> <p>The surveyor observed the signed exit door from the underground parking area to the interior stairwell was locked and needed a key fob to open it. The MC-C stated that during construction this locking arrangement was approved by the Fire Marshal.</p> <p>The surveyor explained to the MC-C that documentation showing this was approved shall be provided or the locking arrangement removed from the door.</p> <p>The deficient conditions were visually verified by the MC-C accompanying on the tour. The surveyor explained to the MC-C the following:</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 775		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(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.</p> <p>(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.</p>	0 810		

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0 810	<p>Continued From page 13</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the annual training documentation on the fire safety and evacuation plan for residents and for employees at new hire and semi-annually. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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 potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>A record review and interview were conducted on January 22, 2025, at approximately 1:30 p.m. with maintenance coordinator (MC)-C on the fire</p>	0 810		

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0 810	<p>Continued From page 14</p> <p>safety and evacuation plan for the facility and training for employees and residents.</p> <p>TRAINING:</p> <p>During record review the surveyor MC-C stated they could not provide documentation of training on the fire safety and evacuation plan for the employees or residents.</p> <p>The surveyor explained to the MC-C that training on the fire safety and evacuation plan shall be conducted at new hire and twice per year thereafter for employees and be offered to the residents once per year. The training shall be documented.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 810		
01440 SS=D	<p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</p> <p>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.</p> <p>(b) The direct supervision of staff performing</p>	01440		

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01440	<p>Continued From page 15</p> <p>delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-E).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>ULP-E began employment on April 15, 2024. ULP-E's employee record showed documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services, but it was completed by licensed practical nurse (LPN)-F.</p> <p>On January 22, 2025, at 3:30 p.m., vice president</p>	01440		

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01440	<p>Continued From page 16</p> <p>of operations (VPO)-B stated the 30-day supervisions should be completed by the registered nurse (RN), not the LPN. VPO-B further stated it may have happened when the RN was out for a medical emergency.</p> <p>The licensee's Supervision of Staff- Delegated Services policy dated August 1, 2021, indicated staff who provide delegated nursing or therapy tasks to residents will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01440		
01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in</p>	01620		

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01620	<p>Continued From page 17</p> <p>the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>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) conducted an admission assessment and a reassessment within 14-days following admission date for one of one resident (R5), and ongoing nursing assessments not to exceed every 90-days thereafter for two of two residents (R3 and R4).</p> <p>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).</p> <p>The findings include:</p> <p>R3 R3 was admitted to the licensee and began receiving assisted living services on January 30, 2024.</p> <p>On January 22, 2025, at 7:25 a.m, the surveyor observed ULP-D assist R3 with morning activities of daily living (ADLs) and completed R3's</p>	01620		

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01620	<p>Continued From page 18</p> <p>scheduled blood glucose testing.</p> <p>R3's record included 90-day assessments completed on September 17, 2024, and December 17, 2024, which indicated 94 days between assessments.</p> <p>R4 R4 was admitted to the licensee and began receiving assisted living services on February 12, 2024.</p> <p>R4's record included 90-day assessments completed on June 12, 2024, September 17, 2024, and December 17, 2024, which indicated 97 days and 91 days had passed between assessments.</p> <p>R5 R5 was admitted to the licensee and began receiving assisted living services on December 18, 2024.</p> <p>R5's 14-day assessment was completed on January 2, 2025, which indicated 17 days had passed since admission assessment. Furthermore, the 14-day assessment did not follow the uniform assessment tool and was lacking advanced health care directive/ code status and spiritual/ cultural components.</p> <p>On January 22, 2025, at 3:50 p.m., director of nursing (DON)-A stated an alert is given in Yardi (electronic charting software) several days before the assessment is due. Assessments were not completed on time and it is unknown why but that is our error.</p> <p>The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated</p>	01620		

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01620	Continued From page 19 resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent	01700		

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01700	<p>Continued From page 20</p> <p>diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.</p> <p>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) conducted an individualized medication assessment with the required content for one of three residents (R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R3 was admitted to the licensee and began receiving assisted living services on January 30, 2024.</p> <p>On January 22, 2025, at 7:25 a.m, the surveyor observed ULP-D assist R3 with morning activities of daily living (ADLs) and completed R3's scheduled blood glucose testing.</p> <p>R3's Service Plan Detail dated January 22, 2025, indicated R3 received assistance with chronic illness management, medication management, activities of daily living (ADLs), dressing, toileting, meals, housekeeping, and laundry.</p>	01700		

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01700	<p>Continued From page 21</p> <p>R3's MN JSL Medication/Treatment Assessment Results dated April 27, 2024, was completed by licensed practical nurse (LPN)-F. In addition, the assessment was not updated until January 22, 2025, which was 180 days late.</p> <p>On January 23, 2025, at 3:22 p.m., director of nursing (DON)-A stated they were unaware the LPN could not complete resident assessments and an RN would complete the assessments going forward.</p> <p>The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated residents receiving assisted living services would have subsequent reviews conducted, dated, and signed by the registered nurse who conducted the assessment.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	01700		
01890 SS=D	<p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for one of three residents (R6).</p>	01890		

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01890	<p>Continued From page 22</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>On January 22, 2025, at 8:45 a.m., the surveyor, along with unlicensed personnel (ULP)-D observed R6's medication supply. The surveyor found R6's acetaminophen 500 milligrams (mg) and Senna-S (stool softener) 8.6-50 mg to both have expired on September 17, 2024.</p> <p>R6's record included signed provider orders dated January 13, 2025 that included an order for acetaminophen 500 mg tablet take two tablets by mouth three times daily and acetaminophen 500 mg tablet take two tablets by mouth every six hours as needed (PRN) for pain. In addition R6's provider orders included an order for senna docusate 8.6-50 mg take one to two tablets twice daily PRN for constipation.</p> <p>R6's record included the eMAR Summary (medication administration record) dated December 24, 2024, through January 22, 2025, which indicated R6 received the scheduled acetaminophen three times daily from January 1, 2025, through January 21, 2025, and the morning of January 22, 2025.</p> <p>On January 22, 2025, at 8:47 a.m., ULP-D stated nursing audits medication supplies for expiration</p>	01890		

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01890	<p>Continued From page 23</p> <p>dates during medication delivery and occasionally will request assistance from lead resident assistants (RA) to check medication supplies for expiration dates.</p> <p>On January 22, 2025, at 10:59 a.m., director of nursing (DON)-A stated nursing audits medication supplies for expiration when delivering cycle-fill medications and on occasion delegates random checks to lead RA's.</p> <p>The licensee's 7.19 Medication Disposal policy dated August 1, 2021, indicated expired medications managed by [licensee] will be disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers will be destroyed</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: seven (7) days</p>	01890		
02310 SS=D	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide appropriate care and services according to acceptable health care, medical, or nursing standards related to secure oxygen tank storage for one of one</p>	02310		

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02310	<p>Continued From page 24</p> <p>residents (R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>On January 22, 2025, at 10:10 a.m., surveyor observed three portable oxygen tanks standing upright on the floor in R5's bedroom. The oxygen tanks were not secured in a noncombustible rack.</p> <p>On January 22, 2025, at 11:03 a.m., director of nursing (DON)-A stated portable oxygen tanks are to be stored upright, in an oxygen tank storage rack. Staff are trained to place empty oxygen tanks back into the provided storage rack after use.</p> <p>The licensee's 7.31 Oxygen policy dated August 1, 2021, indicated oxygen cylinders must remain upright but did not address secure storage.</p> <p>The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over.</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2025
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NAME OF PROVIDER OR SUPPLIER WILLOWS LANDING SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 9872 HART BLVD. MONTICELLO, MN 55362
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Type: Full
Date: 01/21/25
Time: 11:10:58
Report: 1041251017

Food and Beverage Establishment Inspection Report

Page 1

Location:

Willows Landing Senior Living
9872 Hart Blvd.
Monticello, MN55362
Wright County, 86

Establishment Info:

ID #: 0038890
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3204289586
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12E

MN Rule 4626.0275E Store food preparation or dispensing utensils that are used with non-TCS foods, such as ice, in a clean, protected location.

AT TIME OF INSPECTION, THE ICE SCOOP WAS STORED ON THE ICE WITH THE HANDLE ON THE ICE. STORE ICE SCOOP IN A CLEAN, PROTECTED LOCATION.

Comply By: 01/21/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE A HAND WASHING SIGN AT THE HAND SINK IN THE DISH ROOM

Comply By: 01/28/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = at 162 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: 01/21/25
Time: 11:10:58
Report: 1041251017
Willows Landing Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Prep Cooler
Temperature: 39 Degrees Fahrenheit - Location: SLICED HAM
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 38 Degrees Fahrenheit - Location: SHREDDED LETTUCE-BOTTOM UNIT
Violation Issued: No

Process/Item: Hot Holding
Temperature: 181 Degrees Fahrenheit - Location: BBQ PORK
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: MAC AND CHEESE
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: COOKED PASTA
Violation Issued: No

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

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 1041251017 of 01/21/25.

Certified Food Protection Manager: JACLYN HEMINGSEN

Certification Number: 114283 Expires: 11/30/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Linda Heinen
Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us

Report #: 1041251017

Food Establishment Inspection Report



**Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud**

No. of RF/PHI Categories Out

1

Date 01/21/25

No. of Repeat RF/PHI Categories Out

0

Time In 11:10:58

Legal Authority MN Rules Chapter 4626

Time Out

Willows Landing Senior Living	Address 9872 Hart Blvd.	City/State Monticello, MN	Zip Code 55362	Telephone 3204289586
License/Permit # 0038890	Permit Holder	Purpose of Inspection Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

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

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

Risk factors (RF) are improper practices or procedures 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

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

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

Food Recalls:

Person in Charge (Signature)

Date: 01/22/25

Inspector (Signature)

Linda Zinen