Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 6, 2023

Licensee
New Perspective Arden Hills
3565 Pine Tree Drive
Arden Hills, MN 55112

RE: Project Number(s) SL39608015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on November 10, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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 survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. 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 actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:

https://www.web.health.state.mn.us/form/HRD-Appeals-Form

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 MDH 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. To submit a hearing request, please visit **https://www.web.health.state.mn.us/form/HRD-Appeals-Form**.

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39608	A. BUILDING: _____ B. WING _____	11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE ARDEN HILLS	3565 PINE TREE DRIVE ARDEN HILLS, MN 55112

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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: SL39608015-0 On November 6, 2023, through November 8, 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 98 active residents; 35 residents whom were receiving services under the Provisional Assisted Living with Dementia Care license.	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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 6, 2023, 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		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 2 (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 establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for two of two employees (unlicensed personnel (ULP)-B, ULP-G) while providing personal cares. Additionally, the licensee failed to ensure proper cleaning of a shared whirlpool tub. 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: PERSONAL CARES On November 7, 2023, at 8:37 a.m., surveyor entered R3's room and observed ULP-B and ULP-G wearing gloves performing perineum care. After perineum care, ULP-B applied a clean brief and pulled up R3's pants. After ULP-G removed	0 510		

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0 510	Continued From page 3 soiled under pad and brief, ULP-G assisted R3 by grabbing R3's hands with same gloves on and sat R3 to the edge of the bed. ULP-B gathered clean shirt and sling for the mechanical lift, moved wheelchair nearby, and placed the sling on R3. Surveyor observed back of R3's undershirt to be wet before the sling was placed around R3. R3 was placed in the wheelchair and ULP-B brought R3 into the bathroom. Without changing gloves or performing hand hygiene, ULP-B set up R3's toothbrush and wiped out R3's bathroom cup by rubbing the inside of the cup while rinsing with water. ULP-B then brought R3 out into the living room, applied foot pedals to the wheelchair, removed gloves and took the trash out. ULP-G removed the soiled bedding from the bedroom then removed gloves. Both ULP-B and ULP-G brought R3 down to the dining room on another level. On November 7, 2023, at 9:00 a.m., ULP-B stated gloves should have been removed and hands washed after perineum care. ULP-B stated s/he would normally use the "double glove" method (apply two gloves to each hand) because if gloves were removed and something happened, gloves wouldn't be readily available. ULP-B and ULP-G both stated they did not perform hand hygiene. On November 8, 2023, at 1:25 p.m., clinical nurse supervisor (CNS)-A stated ULPs were expected to perform hand hygiene before and after a task, and after removing gloves. CNS-A stated ULPs could not use the "double glove" method. WHIRLPOOL TUB During facility tour on November 6, 2023, at 11:30 a.m., surveyor observed a layer of dirt on three sides of a shared whirlpool tub within a spa room.	0 510		

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0 510	Continued From page 4 On November 8, 2023, at 12:07 p.m., ULP-I stated housekeeping staff were responsible for maintaining the spa room. On November 8, 2023, at 1:10 p.m., environmental services director (ESD)-H stated housekeeping staff who cleaned in memory care were responsible for checking the spa room to make sure it looked clean. ESD-H stated the spa room was never used and was surprised to find it dirty and agreed housekeeping staff were not checking/cleaning the spa room. The licensee's Use of Gloves policy revised July 7, 2023, indicated staff were required to wash hands between glove changes, change gloves if a glove becomes torn or heavily soiled when additional tasks must be performed on the resident, and gloves to never be used after caring for a resident. The licensee's Hand washing policy revised July 7, 2023, indicated proper hand washing techniques should be used before and after direct contact with a resident, if moving from a contaminated-body site to a clean-body site during resident care, and after removing gloves or gowns. The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 30, 2020, directed health care workers to wash their hands immediately before touching a [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. No further information was provided.	0 510		

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0 510	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730		

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0 730	Continued From page 6 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure records included documentation of services provided as identified in the service plan for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 7, 2023, at 8:37 a.m., surveyor observed unlicensed personnel (ULP)-B and ULP-G perform morning cares while R3 was in bed which included toileting and dressing. Then both ULP-B and ULP-G assisted R3 from bed to wheelchair using a mechanical lift. ULP-B brought	0 730		

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0 730	Continued From page 7 R3 into the bathroom to complete grooming, while ULP-G changed sheets on R3's bed and picked up the room. R3 diagnoses included Parkinson's disease, repeated falls, and non-pressure chronic ulcer of left foot due to skin breakdown. R3's Resident Service Agreement signed June 7, 2023, indicated R3 received assistance with bathing, dressing/grooming, skin monitoring, housekeeping, laundry, medication and treatment administration, mobility, transfers, and bowel tracking. R3's Service Checkoff List dated October 1-31, 2023, lacked documentation of services rendered for various services on the following dates: -October 23, 2023, on AM shift; -October 21, 24, and 29, 2023, on PM shift; -October 27, 28, and 31, 2023, on overnight shift. R3's Service Checkoff List dated November 1-6, 2023, lacked documentation of services rendered for various services on the following dates: -November 2, 4, and 5, 2023, on AM shift; -November 5, 2023, on PM shift; and -November 1, 2, and 3, 2023, on overnight shift. On November 8, 2023, at 1:25 p.m., clinical nurse supervisor (CNS)-A stated blank would indicate a documentation error, or that the service was not completed. CNS-A stated they would have to ask the ULP to see if it was a documentation error or if the services was not completed. CNS-A stated the ULPs are supposed to be providing services as stated on the service plan. The licensee's Resident Service Plan policy revised June 22, 2023, indicated team members	0 730		

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0 730	Continued From page 8 responsible for the delivery of care will physically or electronically (for electronic health record systems) sign to attest that the care was completed, and if necessary, any exceptions to care will be documented and communicated immediately to the nurse on duty. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive	0 800		

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0 800	Continued From page 9 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 a facility tour on November 7, 2023, at 12:30 p.m., with licensed assisted living director (LALD)-D and environmental services director (ESD)-H, the surveyor made the following observations of facility hazards and disrepair: A roll of carpet left over from construction was stored in the exit stairway on the lower level in the garage near the fire sprinkler equipment room. Exit stairway enclosures are required to be kept clear of storage and only used for the purpose of exiting in the event of an emergency. The fire-resistant rated door did not automatically close and latch in the memory care laundry room. Fire resistant rated door assemblies are required to automatically close and latch as designed and installed at the time of construction approval. The refrigerators were plugged in with extension cords for electrical power in the three open kitchens of the memory care unit. Electric appliances (the refrigerators) are required to be used according to the manufactures installation instructions and plugged directly into electrical outlets. Electric extension cords are required to be used for temporary power only and not to power a permanently located electric appliance. Open water connections and a shut off valve with no cap or plug to prevent accidentally turning the water on were located above the counter in the three open kitchens of the dementia care unit. Open water connections are required to be	0 800		

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0 800	Continued From page 10 sealed to prevent accidentally turning on water causing flooding and water damage. A door closer was disconnected on the fire-resistant rated door of the maintenance office causing the door to not close automatically. Fire resistant rated door assemblies are required to automatically close and latch as designed and installed at the time of construction approval. The fire door of the trash chute was blocked by garbage and would not close automatically in the event of a fire in the trash/dumpster room in the lower-level garage. The fire-resistant rated trash chute door is required to be maintained as designed and installed and automatically close in the event of a fire in the trash/dumpster room. The documentation provided for maintenance of the stand-by power generator used as part of the emergency preparedness plan indicated maintenance was performed in June and October of 2023. Generators used for stand-by power as part of the facility emergency preparedness plan are required to be maintained and according to NFPA 110. Documentation is required to be kept to reflect the required maintenance intervals. On November 7, 2023, at 12:30 p.m., LALD-D and ESD-H verified these deficient conditions while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE ARDEN HILLS	3565 PINE TREE DRIVE ARDEN HILLS, 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
01640	Continued From page 11 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee or resident to document agreement on the services to be provided for three of three residents (R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01640		

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01640	Continued From page 12 The findings include: R3's Resident Service Agreement effective date October 30, 2023, was unsigned by the resident's representative and the licensee. R4's Resident Service Agreement effective date October 23, 2023, was unsigned by the resident's representative and the licensee. R5's Resident Service Agreement effective date August 18, 2023, was unsigned by the resident's representative and the licensee. On November 8, 2023, at 11:32 a.m., licensed assisted living director (LALD)-D stated they do not have signed service agreements for R4 or R5. On November 8, 2023, at 1:25 p.m., clinical nurse supervisor (CNS)-A stated s/he would discuss the service plan changes to the resident and resident's representative, and LALD-D was responsible for obtaining signatures. CNS-A stated s/he would update LALD-D of the changes and request signatures. On November 8, 2023, at 1:40 p.m., CNS-A stated when the resident assessment information is entered into the computer system, the service plan generates. The service plan then gets printed and signed. CNS-A stated s/he was not sure why this was not completed for the residents reviewed. The licensee's Resident Service Plan policy revised June 22, 2023, indicated the service plan is revised and signed by a nurse and the resident and/or the resident's legal representative any time	01640		

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01640	Continued From page 13 services change based on changes in the resident's needs or preferences, and any time the Community's fee schedule changes. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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 transcribe physician orders for one of three residents (R3) receiving medication management. 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	01760		

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01760	Continued From page 14 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: R3's Resident Service Agreement signed on June 7, 2023, indicated R3 received medication management services. R3's Medication and Treatment and Therapies Management Plan dated October 11, 2023, indicated medication passers and licensed nurses were responsible for administering oral, topical, and rectal medications. The plan also indicated medication administration instructions were located on the medication administration record (MAR). R4's electronic MAR (eMAR) dated November 2023, included the following medication instructions: -loperamide 2 milligram (mg) capsule - take two capsules by mouth as needed (PRN), max dose 16 mg per 24 hours; -loperamide 2 mg capsule - take one capsule by mouth PRN; -miconazole 2% cream - apply a small amount topically twice (BID) daily PRN to affected area; and -milk of magnesia suspension -administer 30 milliliters (ml) by mouth once daily PRN for small or no bowel movement in three days. R3's Community Standing Orders signed June 30, 2023, included the following orders: -loperamide 4 mg by mouth PRN loose stool, then 2 mg for each additional loose stool with maximum dose of 16 mg/24 hours;	01760		

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01760	Continued From page 15 -antifungal Miconazole 3% cream or powder - after nurse assessment, apply small amount BID PRN; and -administer milk of magnesia 1200 mg/15 ml - administer 30 ml by mouth once daily PRN. On November 8, 2023, at 12:07 p.m., unlicensed personnel (ULP)-I stated the loperamide dose was not clear how much to give, so ULP-I stated they would contact the nurse for instructions. On November 8, 2023, at 1:25 p.m., clinical nurse supervisor (CNS)-A stated the pharmacy would profile the provider orders (transcribe) onto the MAR. CNS-A stated they would have to reach out to the pharmacy to have that corrected because the instructions were not clear. The licensee's Medication Management policy revised April 12, 2023, indicated all new or changes in medication orders would be transcribed into eMAR by a licensed nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	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	01880		

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01880	Continued From page 16 review, the licensee failed to ensure medications were properly secured for only authorized personnel for one of four residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 had diagnoses of acute post hemorrhagic anemia (blood loss), symptoms and signs involving cognitive functions and awareness, cerebral infarction due to embolism of right middle cerebral artery (stroke), and weakness. R6's Resident Service Agreement signed August 7, 2023, indicated R6 received bathing assist, assistance with dressing/grooming, medication and treatment administration, assist of two unlicensed personnel (ULP) for mechanical lift transfers, and catheter care. R6's Medication and Treatment and Therapies Management Plan dated August 7, 2023, required R6's medications to be stored in a locked medication cart and oral, topical, and rectal medications were to be administered by medication passers or licensed nurses. On November 7, 2023, at 9:45 a.m., R6 stated family had requested medication management as they used to set up R6's medications on a weekly basis. Surveyor observed multiple medications	01880		

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01880	Continued From page 17 within R6's apartment. Some medications were on the center island of the kitchen, and some were the bedroom next to the bed. The following medications were accessible to R6: -Icy Hot pro dry spray -Astepro allergy nasal spray; -Eye Itch Relief antihistamine eye drops; -Zaditor antihistamine eye drops; -ClearLax polyethylene glycol for constipation; -fluocinonide 0.05% ointment (two tubes); -triple antibiotic ointment; -Refresh Plus eye drops (two single use doses); -Tussin DM cough and chest; -Benadryl allergy tablets; -Hemp pain relief cream 2500 milligram (mg); -8-hour arthritis pain relief 650 mg tablets; -melatonin 10 mg tablets for sleep; and -Pepcid AC 20 mg tablets for stomach acid. On November 8, 2023, at 1:25 p.m., clinical nurse supervisor (CNS)-A stated they had not been made aware of any unsecured medications in R6's room. CNS-A stated they would need to speak with R6's daughter who was involved in R6's care. CNS-A stated ULPs that administer medications should notify the nurse if they observed medications in a resident's room so they could make sure there were no medication interactions. The licensee's Medication Management policy revised April 12, 2023, indicated the resident's medication plan would reflect the method of reordering, delivery, storage, and security if applicable. Additionally, the [licensee] requires a prescription for all medications that it manages for its residents, including over-the-counter medications, and dietary supplements. No further information was provided.	01880		

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01880	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	01940		

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01940	Continued From page 19 by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included Parkinson's disease, repeated falls, and non-pressure chronic ulcer of left foot due to skin breakdown. R3's prescriber orders electronically signed on September 8, 2023, ordered to start Tubigrip compression bandage (promotes blood flow) from midfoot to below the knee on right leg and ankle to below the knee on left leg, on in the morning (AM) for 12 hours and off in the evening (PM) for 12 hours. R3's Registered Nurse (RN) Comprehensive Assessment dated October 30, 2023, indicated R3 did not wear Tubigrip compression bandage. R3's record lacked a treatment therapy management plan to include the following content: -a statement of the type of services that will be provided; -documentation of specific resident instructions	01940		

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01940	Continued From page 20 relating to the treatment or therapy administration; -identification of the treatment or therapy that will be delegated to unlicensed personnel; -procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. During observation and interview on November 7, 2023, at 8:37 a.m., surveyor observed unlicensed personnel (ULP)-B and ULP-G perform morning cares while R3 was in bed which included toileting and dressing. ULP-G stated R3 used to wear ACE wraps to left foot due to a wound but wound had healed and R3 no longer required any treatments to lower extremities. On November 8, 2023, at 11:25 a.m., R3's significant other (R7) stated R3 never had Tubigrip compression bandage. On November 8, 2023, at 12:07 p.m., ULP-I stated R3 never had Tubigrip compression bandage and only wore grip socks that were provided by the hospital. On November 8, 2023, at 1:25 p.m., surveyor asked clinical nurse supervisor (CNS)-A if R3 had Tubigrip compression bandage, and CNS-A stated, "I will follow up on that." The licensee's Treatment or Therapy Management Services revised March 21, 2023,	01940		

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01940	Continued From page 21 indicated the RN was responsible for the following: -receiving orders for treatment or therapy services; -implementing treatment or therapy services; -providing or delegating treatments or therapy services to licensed or unlicensed personnel; -overseeing accurate documentation of treatment or therapy services; -maintaining an individualized resident treatment or therapy services record; -monitoring and evaluating treatment or therapy services; -communicating information regarding treatment or therapy services with the prescribing physician; and -educating and communicating with the resident or resident's legal representative about treatments or therapy services they are receiving. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	01960		

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01960	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered, and any follow up procedures provided to meet the resident's needs for one of two residents (R3) with treatment and/or therapies. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 diagnoses included Parkinson's disease, repeated falls, and non-pressure chronic ulcer of left foot due to skin breakdown. R3's prescriber orders electronically signed on September 8, 2023, ordered to start Tubigrip compression bandage (promotes blood flow) from midfoot to below the knee on right leg and ankle to below the knee on left leg, on in the morning (AM) for 12 hours and off in the evening (PM) for 12 hours. R3's Registered Nurse (RN) Comprehensive Assessment dated October 30, 2023, indicated R3 did not wear Tubigrip compression bandage. R3's medical record lacked documentation	01960		

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01960	Continued From page 23 Tubigrip compression bandages were applied daily as ordered. During observation and interview on November 7, 2023, at 8:37 a.m., surveyor observed unlicensed personnel (ULP)-B and ULP-G perform morning cares while R3 was in bed which included toileting and dressing. ULP-G stated R3 used to wear ACE wraps to left foot due to a wound but wound had healed and R3 no longer required any treatments to lower extremities. On November 8, 2023, at 11:25 a.m., R3's significant other (R7) stated R3 never had Tubigrip compression bandage. On November 8, 2023, at 12:07 p.m., ULP-I stated R3 never had Tubigrip compression bandage and only wore grip socks that were provided by the hospital. On November 8, 2023, at 1:25 p.m., surveyor asked clinical nurse supervisor (CNS)-A if R3 had Tubigrip compression bandage, and CNS-A stated, "I will follow up on that." The licensee's Treatment or Therapy Management Services revised March 21, 2023, indicated the RN was responsible for the following: -receiving orders for treatment or therapy services; -implementing treatment or therapy services; -providing or delegating treatments or therapy services to licensed or unlicensed personnel; -overseeing accurate documentation of treatment or therapy services; -maintaining an individualized resident treatment or therapy services record; -monitoring and evaluating treatment or therapy	01960		

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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
01960	Continued From page 24 services; -communicating information regarding treatment or therapy services with the prescribing physician; and -educating and communicating with the resident or resident's legal representative about treatments or therapy services they are receiving. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (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 storage of cleaning supplies in the secured unit. 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 the residents).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39608	A. BUILDING: _____ B. WING _____	11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE ARDEN HILLS	3565 PINE TREE DRIVE ARDEN HILLS, 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 25 The findings include: During observation and interview on November 7, 2023, at 12:55 p.m., the surveyor observed the contents of the kitchen cabinets in the secured memory care unit. The unsecured contents included Fabuloso floor cleaner, Comet 3-20 disinfecting-sanitizing bathroom cleaner, and a refillable bottle of hand soap. Surveyor observed a resident ambulating within the dining room and a resident self-propelling in a wheelchair nearby. Environmental services director (ESD)-H stated cleaning supplies were supposed to be locked in the housekeeping closet. On November 8, 2023, at 12:07 p.m., unlicensed personnel (ULP)-K stated housekeeping would do the cleaning of tables and floors after meals. ULP-J stated the housekeeper would usually store the cleaners in the cabinets under the sink. The licensee's undated Hazard and Risk Assessment Tool-Memory Care Risk Assessment indicated action taken to mitigate risk of chemicals stored in closet/cart were to educate all team members of hazard of unlocked chemicals. The licensee's Cleaning and Disinfecting Common Areas policy revised on March 15, 2023, indicated staff use Comet Disinfecting-Sanitizing Bathroom cleaner for sink and toilet bowls. The licensee's Housekeeping Carts policy revised August 29, 2022, indicated the housekeeping cart was to be stored in the designated, locked area when not in use. The Fabuloso All Purpose Cleaner Liquid	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39608	A. BUILDING: _____ B. WING _____	11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE ARDEN HILLS	3565 PINE TREE DRIVE ARDEN HILLS, 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 26 Lavender Safety Data Sheet dated May 22, 2015, indicated it could cause skin irritation, may cause an allergic skin reaction, causes serious eye irritation, and may be harmful if swallowed in large quantities. Get medical attention if symptoms persist after first aid. The Comet Disinfecting-Sanitizing Bathroom Cleaner Safety Data Sheet dated June 18, 2015, indicated for personal precautions, use personal protective equipment, do not get in eyes, on skin, or on clothing. Get medical attention if irritation or symptoms persist after first aid. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *11/06/23*
Time: 13:30:00
Report: 1025231251

Food and Beverage Establishment Inspection Report

Location:
New Perspective Arden Hills
3565 Pine Tree Drive
Arden Hills, MN55112
Ramsey County, 62

Establishment Info:
ID #: 0042184
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

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

Milk stored in memory care neighborhood kitchen at 44 deg F, refrigerator display at 47 deg F, equipment does not meet standards of MN 4626.0506, do not use for the storage of TCS items for residents. Milk discarded.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: Dish machien
Violation Issued: No

Quaternary Ammonia: = 300 PPM at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Display
Temperature: (47) Degrees Fahrenheit - Location: Memory care refrigerator display
Violation Issued: No

Process/Item: Milk
Temperature: 44 Degrees Fahrenheit - Location: Memory care refrgierator
Violation Issued: Yes

Type: Full
Date: *11/06/23*
Time: 13:30:00
Report: 1025231251
New Perspective Arden Hills

Food and Beverage Establishment Inspection Report

Process/Item: BBQ
Temperature: 77 Degrees Fahrenheit - Location: Cooling < 1 hr
Violation Issued: No

Process/Item: Cut melon
Temperature: 44 Degrees Fahrenheit - Location: Upright cooler ice machine, cooling from ambient
Violation Issued: No

Process/Item: Ambient
Temperature: 38 Degrees Fahrenheit - Location: Upright cooler ice machine
Violation Issued: No

Process/Item: Ambient
Temperature: 40 Degrees Fahrenheit - Location: Drawer cooler
Violation Issued: No

Process/Item: Ham
Temperature: 40 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Process/Item: Hot water
Temperature: 137 Degrees Fahrenheit - Location: Dipper well ice cram
Violation Issued: No

Process/Item: Beef
Temperature: 40 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

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

Discussed employee health and hygiene, employee illness exclusion and reporting, cell phone use, handwashing, illness log in office, communication records of employee exclusion available (text), disposables for quarantine
BBQ sauce cooling in prep sink ice bath @ 77deg F cooling report less than 1 hour
TMD and wipes available at expo
Eggs unpasteurized used for full cooking, not served raw or undercooked or batch scrambled
Raw animal food cooked to minimum required cook temperature
Foods from an approved source
Pest control measures on-site

Neighborhood kitchens have refrigerators which do not meet the requirements of MN 4626.0506 and therefore cannot be used for the storage of cold TCS items (non-TCS items or employee/staff food/bev if separated from any resident items OK).

Facility has a pool, will verify license with Ramsey Co EH.
Facility has a bistro area, but reported not in use except for coffee due to census numbers.
Facility has additional memory care neighborhood kitchens but only one reported in use during inspection.

Type: Full
Date: *11/06/23*
Time: 13:30:00
Report: 1025231251
New Perspective Arden Hills

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 1025231251 of 11/06/23.

Certified Food Protection Manager: Mark Anderson

Certification Number: FM5700 Expires: 04/08/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

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

Report #: 1025231251

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1	Date	11/06/23
No. of Repeat RF/PHI Categories Out	0	Time In	13:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

New Perspective Arden Hills	Address: 3565 Pine Tree Drive	City/State: Arden Hills, MN	Zip Code: 55112	Telephone
License/Permit #: 0042184	**Permit Holder**	**Purpose of Inspection:** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	(IN)	OUT	N/A	N/O	Proper cooling time & temperature		
21	(IN)	OUT	N/A	N/O	Proper hot holding temperatures		
22	IN	(OUT)	N/A		Proper cold holding temperatures	X	
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) [signature] **Date:** 11/06/23

Inspector (Signature) [signature]