Electronically Delivered

January 24, 2025

Licensee
Kangars Residential Home LLC
141 64 1/2 Way Northeast
Fridley, MN 55432

RE: Project Number(s) SL40329015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on November 15, 2024, 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 . . ."

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

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.

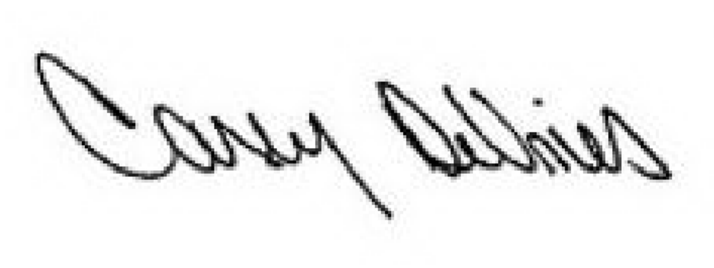
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	40329	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANGARS RESIDENTIAL HOME LLC	141 64 1/2 WAY NORTHEAST FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40329015-0 On November 12, 2024, through November 15, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents, both who received services under the provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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0 480	Continued From page 1 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 manner that prevents contamination before storage; (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; (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	0 480		

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0 480	Continued From page 2 and in good condition; (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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 13, 2024, 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.	0 480		

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0 650	Continued From page 3	0 650		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of three employees (unlicensed personnel (ULP)-A). 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	0 650		

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0 650	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Current Employee List indicated ULP-A was hired January 2, 2024. ULP-A provided direct care services to residents. On November 12, 2024, the surveyor observed ULP-A administer medication to R1. ULP-A's employee record lacked the following training: - maintenance of a lean and safe environment; - unplanned times away medication preparation; - reading and recording temperature, pulse, and respirations of the resident; and - appropriate techniques in personal hygiene and grooming: o Hair care On November 13, 2024, at 11:55 a.m., clinical nurse supervisor (CNS)-C stated they had educated ULPs on all of the training topics listed above, however the training topics were not included on the skills check list and stated they used the same skills check list for all ULPs. On November 13, 2024, at 12:02 p.m., ULP-A stated they received education on the above listed content. ULP-A stated CNS-C provided the education to them upon hire along with other trainings. The licensee's undated policy titled, MN Statute 144G.42, Subd. 8 Employee Records Policy, indicated, "Employee records must include the following information:	0 650		

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0 650	Continued From page 5 a. Evidence of current professional licensure, registration, or certification if licensure, registration or certification is required b. Records of orientation, required annual training, infection control training and competency evaluations c. Current signed job descriptions, including qualifications, responsibilities and identification of staff persons providing supervision d. Documentation of annual performance reviews that identify areas of improvement needed and training needs e. For individuals providing assisted living services, verification that required health screenings under Subd. 9 (TB prevention and control) have taken place and the dates of those screenings; and f. Documentation of the background study as required under section 144.057. 2. Each record must be retained for at least three (3) years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at or be under contract with the facility. 3. If the facility ceases operation, employee records must be maintained for three (3) years after facility operations cease." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	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	0 660		

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0 660	Continued From page 6 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of two employees (unlicensed personnel (ULP)-A). 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: ULP-A was hired on January 2, 2024, to provide direct care and services to residents.	0 660		

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0 660	Continued From page 7 On November 12, 2024, at 1:55 p.m., the surveyor observed ULP-A perform medication administration to R1. ULP-A's employee record included After Visit Summary (AVS) dated March 7, 2024, which indicated a negative result for ULP-A's TST test result for a TST administered on March 5, 2024. ULP-A's employee record also included AVS dated February 20, 2024, which indicated ULP-A received a TST on February 20, 2024, and instruction for ULP-A to return to the clinic with 48-72 hours to have the TST read. ULP-A's employee record lacked evidence the TST administered on February 20, 2024, result was read or other evidence of TB screening such as a blood test, was completed. On November 12, 2024, at 1:24 p.m., clinical nurse supervisor (CNS)-C stated ULP-A missed a reading for the first TST which was administered on February 20, 2024. ULP-A took another test on March 5, 2024, and had the result read on March 7, 2024, ULP-A was supposed to receive another test, but they did not do it. CNS-C stated they were not aware ULP-A missed the reading for the first step TST. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The licensee's undated Employee Records policy indicated, "For individuals providing assisted living services, verification that required health screenings under Subd. 9 (TB prevention and control) have taken place and the dates of those	0 660		

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0 660	Continued From page 8 screenings". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 680		

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0 680	Continued From page 9 licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated August 1, 2021, lacked evidence of the following required content: - procedures for tracking of staff and patients; - policies and procedures for medical documents; - polices and procedures for volunteers; - role under a waiver declared by secretary; - sharing information on occupancy/needs; and - quarterly review of missing resident policy. On November 13, 2024, at 1:43 p.m., clinical nurse supervisor (CNS)-C stated they were aware of the requirements for volunteers and medical documents, and they did not know how they missed those topics. CNS-C stated they were not aware of the requirement for role under a waiver declared by secretary. CNS-c also stated they reviewed all documents every two months, but they did not have documentation for the reviewed documents. The licensee's Emergency Preparedness Plan policy dated August 1, 2021, indicated,	0 680		

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0 680	Continued From page 10 "Policy Statement: [Licensees' name] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensees' name] will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency. Definition: An emergency is a natural or human made event that significantly disrupts the environment of care. For example, damage to a residence, such as severe wind, storm or tornado that disrupts care and treatment, loss of utilities due to floods, civil disturbances, accidents or emergencies in the residences or their communities; or that results in sudden significantly changed or increased demands for the agency's services." The licensee's Missing Resident/Elopement Plan last revised on August 1, 2021, indicated, "The missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify	0 950		

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0 950	Continued From page 11 a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative in writing in the contract and failed to provide the required verbatim notice on its own separate page for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 950		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANGARS RESIDENTIAL HOME LLC	141 64 1/2 WAY NORTHEAST FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 950	Continued From page 12 safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's Assisted Living Contract was signed on April 30, 2024. R2 R2's Assisted Living Contract was signed on September 12, 2024. The licensee's Assisted Living Contract form utilized for the above listed residents lacked the required verbatim "right to designate a representative for certain purposes" notice on a document separate from the contract. On November 13, 2024, at 11:23 a.m., clinical nurse supervisors (CNS)-C stated they were not aware of the requirement to include "right to designate a representative for certain purposes" notice in the assisted living contract and on a document separate from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	01370		

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01370	Continued From page 13 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	01370		

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01370	Continued From page 14 Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on January 2, 2024, to provide direct care and services to residents. On November 12, 2024, at 1:55 p.m., the surveyor observed ULP-A perform medication administration to R1. ULP-A's employee record lacked the following competency evaluations: -care and use of hearing aids. On November 13, 2024, at 11:47 a.m., clinical nurse supervisor (CNS)-C stated they did not have a resident with hearing aids now or in the past, therefore they did not train the ULPs on the care and use of hearing aids. On November 13, 2024, at approximately 12:05 p.m., ULP-A stated they were not trained on the care and use of hearing aids because they never had a resident who had hearing aids. No further information was provided.	01370		

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01370	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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. (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 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one	01620		

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01620	Continued From page 16 of two residents (R1). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted to the licensee on April 30, 2024, and began receiving assisted living services. R1's diagnosis included Alzheimer's disease, and wedge compression fracture of unspecified thoracic. R1's Assisted Living Resident Assistant Care Plan dated April 30, 2024, indicated R1 received assistance with medication administration, grooming, dressing, positioning, eating, transferring, bed bath, and continence care. R1's record included admission assessment completed on April 30, 2024, 14-day nursing assessment completed on May 14, 2024, 30-day assessment completed on May 31, 2024, and 90-day nursing assessments completed on July 30, 2024. R1's record lacked 90-day assessment which was due on October 28, 2024. On November 13, 2024, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-C stated	01620		

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01620	Continued From page 17 they were counting 90 days from date of admission and not from the last assessment date. The licensee's undated Comprehensive Resident Assessment read " 12. Ongoing assessments will be completed based on resident's needs, change in condition or resident's request. Reassessments must be done no more than 90 days after the previous assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date 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.	01640		

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01640	Continued From page 18 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for one of two residents (R2). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 was admitted to the licensee on September 12, 2024, and started receiving assisted living services. R2's diagnosis included Parkinson's disease. R2's unsigned service plan dated September 13, 2024, indicated R2 received assistance with dressing, grooming, bathing, continence care, positioning, eating, walking, transferring, and medication administration. On November 13, 2024, at 11:35 a.m., clinical nurse supervisor (CNS)-C stated they forgot to	01640		

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01640	Continued From page 19 attach the service plan document to an email sent to R2's family member for signature. The licensee's Service Plans policy dated November 23, 2023, indicated the service plan shall be signed by the resident or financially responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific medication administration instructions for each resident was documented in the resident's record for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

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01750	Continued From page 20 safety but had the potential to have harmed a resident's health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted to the licensee on April 30, 2024, and began receiving assisted living services. R1's diagnosis included Alzheimer's disease, and wedge compression fracture of unspecified thoracic. R1's Assisted Living Resident Assistant Care Plan dated April 30, 2024, indicated R1 received assistance with medication administration, grooming, dressing, positioning, eating, transferring, bed bath, and continence care. On November 12, 2024, at 1:55 p.m., the surveyor observed unlicensed personnel (ULP)-A perform medication administration to R1. The surveyor observed ULP-A crush two tablets of Quetiapine 25mg, mix it with apple juice and administer it to R1. On November 13, 2024, at 10:15 a.m., the surveyor inquired with clinical nurse supervisor (CNS)-C if there was an order to crush R1's medications. The surveyor observed CNS-C look through R1's chart. CNS-C stated they did not see an order to crush medication, "I do not know how I missed it." On November 13, 2024, at 12:08 p.m., the	01750		

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01750	Continued From page 21 surveyor inquired with ULP-A if they had an order to crush medication for R1. ULP-A stated CNS-C told them to crush medication as R1 was not able to take medications whole. ULP-A checked R1's medication administration record and stated, "I do not see where it says crush and mix with apple juice, but it was communicated with [the] hospice nurse." The licensee's Individualized Medication Management Plan & Record dated November 23, 2023, indicated "POLICY: The facility will develop an individualized medication management plan and record based on the nursing assessment and the needs or preferences of the residents. This plan will be developed with the resident and/or resident's representative and this plan will be part of the resident's service plan. Once the medication management plan has been developed, the RN will develop the resident's medication record with detailed information about the medications staff will be managing. PURPOSE: To assure that each resident has a medication plan that clarifies their needs and preferences related to medication administration Services [sic] provided are based on an individualized assessment and state license requirements." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 22 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of two residents (R1). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted to the licensee on April 30, 2024, and began receiving assisted living services. R1's diagnosis included Alzheimer's disease, and wedge compression fracture of unspecified thoracic. R1's Assisted Living Resident Assistant Care Plan dated April 30, 2024, indicated R1 received assistance with medication administration, grooming, dressing, positioning, eating, transferring, bed bath, and continence care. R1's physician order dated April 30, 2024,	01890		

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01890	Continued From page 23 indicated the following order: - Bisacodyl 10mg suppository, insert 1 suppository (10mg) rectally as needed for constipation. On November 13, 2024, at 12:46 p.m., the surveyor observed R1's bisacodyl 10mg suppository, which was expired June 2024. On November 13, 2024, at 1:24 p.m., clinical nurse supervisor (CNS)-C stated they received the medication from the pharmacy in May 2024, and the medication was expired in June 2024. CNS-C stated this was an eye-opening experience; CNS-C stated going forward they will reeducate staff to check expiry dates upon receiving medications from pharmacy. The licensee's Medication Management Services dated November 23, 2023, indicated, "Review of the Resident's Medication Record. The RN or LPN will review each resident's medication record when the nurse is setting up medications and at other appropriate times based on the resident's needs and the resident's medication management services, including during the resident monitoring visit: a. To verify that staff is administering the medications as prescribed and is documenting the administration appropriately with authentication by each staff person by discipline or title b. To review and evaluate the administration of PRN medications c. To observe for signs of medication diversion and d. To evaluate the effectiveness of the medications and identify any drug-to-drug interaction, and untoward or reported side effects. Any issues or concerns will require follow up and	01890		

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01890	Continued From page 24 documentation by the nurse, including communications with the prescriber and pharmacy, education of the resident and/or the resident's representative, and additional training for staff or other appropriate actions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of	01910		

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01910	Continued From page 25 disposition of medications for one of one discharged resident (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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on January 20, 2024, with diagnoses which included malignant neoplasm. The licensee's Discharged Resident/Client Roster dated January 30, 2024, indicated R3 was deceased on January 30, 2024. R3's medication administration record January 20, 2024, to January 29, 2024, indicated R3 took the following medication: - morphine 60 milligrams (mg) Take one every 12 hours; - senna 8.6 mg - Take 2 tablet by mouth twice a day; - creon 24000 unit capsule (cap) take 1 cap three times a day; - verapamil sustained release (SR) 180mg tablet, take 1 tablet once daily; and - Haldol 2mg/milliliter (ml) give 0.5ml three times a day. R3's record included a Narcotic count/ Controlled substance log which indicated disposition for morphine and lorazepam on Disposition of	01910		

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01910	Continued From page 26 Unused Drug section of the log dated January 31, 2024. R3's record lacked evidence of documented disposition of non-narcotic medications for R3 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On November 13, 2024, at 1:25 p.m., clinical nurse supervisor (CNS)-C stated, they did have the form for disposition of medication that they could have used, but it was overlooked, "I think I just forgot about it." The licensee's Medication Disposition or Disposal policy dated November 23, 2023, indicated, " Disposal of Unused or Discontinued Prescription Drugs Managed by our Facility a. Prescription drugs managed and secured by our facility that are left with our facility after the death or termination of services for a resident for whom the drug was prescribed, or any prescription drug permanently discontinued, must be destroyed by the RN / LPN or pharmacist with one other person as a witness. Discontinued or unused drugs will be destroyed within one month or less of the time they are discontinued or the day of death or discharge of the resident. b. Medications that have been stored in the resident's private living space may be treated as household waste and may be destroyed by mixing with substance such as dirt, cat litter or other substance that make it unpalatable and placing in a sealed container (plastic bag or other) and placing in facility trash. They may also be made unusable and unrecognizable and then put into the trash by following instructions from	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40329	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANGARS RESIDENTIAL HOME LLC	141 64 1/2 WAY NORTHEAST FRIDLEY, MN 55432

(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
01910	Continued From page 27 the Minnesota Pollution Control Facility (See http://www.pca.state.mn.us/index.php/living-green/living-green-citizen/household-hazardous-waste/disposing-of-unwanted-medications.html). c. Because all medications must be treated as hazardous waste, if the medications have been stored outside the resident's private living space, they must be disposed of consistent with Minnesota Pollution Control Agency (PCA) requirements, except for controlled substances. Whenever possible, the RN will work with the local pharmacy to see if it can provide a container for non-controlled drugs needing destruction and collect and destroy these drugs on a regular basis. If this service is not available, medications that have been stored outside the resident's private living space must be destroyed using a hazardous waste disposal site and/or hazardous waste hauler, consistent with Minnesota PCA requirements. (Find the PCA's publications on hazardous waste at: http://www.pea.state.nm.us/index.php/waste/waste-permits-and-rules/waste-permits-and-forms/hazardous-waste-publications.html.) d. Documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded in the client's record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 28	02310		
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 two of two residents (R1, R2) with hospital bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on April 30, 2024, and began receiving assisted living services. R1's diagnosis included Alzheimer's disease, and wedge compression fracture of unspecified thoracic. R1's Assisted Living Resident Assistant Care Plan dated April 30, 2024, indicated R1 received	02310		

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	40329	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANGARS RESIDENTIAL HOME LLC	141 64 1/2 WAY NORTHEAST FRIDLEY, MN 55432

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02310	Continued From page 29 assistance with medication administration, grooming, dressing, positioning, eating, transferring, bed bath, and continence care. On November 12, 2024, at 11:15 a.m., during the facility tour with clinical nurse supervisor (CNS)-C the surveyor observed an upper half bed rail on the left side of R1's hospital bed. R1's record included a Bed rail Assessment form completed on April 30, 2024. R1's record lacked the following documentation: -documentation of bed rail measurements for entrapment zones; and -on going assessment of the bed rail use, with each 90-day assessment or with change of condition. R2 R2 was admitted to the licensee on September 12, 2024, and started receiving assisted living services. R2's diagnosis included Parkinson's disease. R2's unsigned service plan dated September 13, 2024, indicated R2 received assistance with dressing, grooming, bathing, continence care, positioning, eating, walking, transferring, and medication administration. On November 12, 2024, at 11:17 a.m., the surveyor observed upper half bed rails on both sides of R2's hospital bed. R2's record included a Bed rail Assessment form completed on September 12, 2024. R2's record lacked the following:	02310		

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	40329	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANGARS RESIDENTIAL HOME LLC	141 64 1/2 WAY NORTHEAST FRIDLEY, MN 55432

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02310	Continued From page 30 -documentation of bed rail measurements for entrapment zones. On November 13, 2024, CNS-C stated entrapment zones for both residents were measured and determined to be safe, but they did not have the measurements documented. They also stated they checked the bed rails every day for safety, and they did do the assessment with the ongoing assessments every 90 days. CNS-C stated they were unable to find the 90-day assessment for R1's bed rail. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) The Minnesota Department of Health (MDH) website, Assisted Living Resources &	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40329	A. BUILDING: _____ B. WING _____	11/15/2024

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KANGARS RESIDENTIAL HOME LLC	141 64 1/2 WAY NORTHEAST FRIDLEY, MN 55432

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02310	Continued From page 31 Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's hospital bed rail should include, but is not limited to: Purpose and intention of the bed rail Measurements The resident's bed rail use/need assessment Risk vs. benefits discussion (individualized to each resident's risks) The resident's preferences Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Subpart 2. Assessment tool elements B. (3) indicated a resident's mobility status must be assessed to include ambulation, transfers, and assistive devices. The licensee's Use of Side Rails policy dated November 23, 2024, indicated, "Side rails will not be used in the assisted living setting except in situations where assessment determines they are necessary for safety of the resident. If the resident or resident's representative wants side	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 32 rails on the bed, facility RN will educate the resident/representative about the risks related to side rails and will assess whether the side rails meet FDA standards. If the side rails do not meet safety guidelines, staff will recommend alternative options to reduce the fall risk. Prescriber orders will be obtained for the side rails if indicated. Purpose o To establish parameters for the safe use of side rails o To clarify facility policy on the need for and the safe use of side rails o To identify documentation requirements if side rails are used" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *11/13/24*
Time: 11:55:13
Report: 1029241402

Food and Beverage Establishment Inspection Report

Location:

KANGARS RESIDENTIAL HOME LLC
141 64 1/2 WAY NORTHEAST
Fridley, MN55432
Anoka County, 02

Establishment Info:

ID #: 0043809
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

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.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO SMALL DIAMETER PROBE THERMOMETER. EXAMPLE PROVIDED. REP INSTRUCTED TO OBTAIN SMALL DIAMETER PROBE THERMOMETER.

Comply By: 11/22/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COOKED SWEET POTATOES HELD BEYOND SAME-DAY SERVICE. DISCARDED BY OPERATOR.

Comply By: 11/13/24

Surface and Equipment Sanitizers

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COLD HOLD/CHICKEN BROTH
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR
Violation Issued: No

Type: Full
Date: *11/13/24*
Time: 11:55:13
Report: 1029241402
KANGARS RESIDENTIAL HOME LLC

Food and Beverage Establishment Inspection Report

Process/Item: COLD HOLD/SALSA
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: No

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

EMPLOYEE ILLNESS REPORTING AND EXCLUSION, VOMIT/FECAL MATTER CLEANUP, EMPLOYEE HANDWASHING, TEMPERATURE CONTROL, AND FOODBORNE ILLNESS PATHOGENS DISCUSSED. ESTABLISHMENT USES NSF/ANSI 184 STANDARD DISHWASHER TO SANITIZE EQUIPMENT AND UTENSILS.

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 1029241402 of 11/13/24.

Certified Food Protection Manager: MALINDA D. PETERS

Certification Number: FM117715 Expires: 04/20/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
MALINDA PETERS
CNSC

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241402

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	0	Date	11/13/24
No. of Repeat RF/PHI Categories Out	0	Time In	11:55:13
Legal Authority MN Rules Chapter 4626		Time Out	

KANGARS RESIDENTIAL HOME LLC	Address: 141 64 1/2 WAY NORTHEAST	City/State: Fridley, MN	Zip Code: 55432	Telephone
License/Permit #: 0043809	**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	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

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

GOOD RETAIL PRACTICES

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

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

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

			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	X	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:** 11/13/24

Inspector (Signature) Trevor McCliment