

State of Ohio
Food Inspection Report
 Authority: Chapters 3717 and 3715 Ohio Revised Code

Name of facility Hotel Versailles		Check one <input checked="" type="checkbox"/> FSO <input type="checkbox"/> RFE	License Number 302	Date 6/25/25
Address 21 W Main ST		City/State/Zip Code Versailles OH 45380		
License holder Renaissance Corp		Inspection Time 80	Travel Time 30	Category/Descriptive C45
Type of inspection (check all that apply) <input type="checkbox"/> Standard <input checked="" type="checkbox"/> Critical Control Point (FSO) <input type="checkbox"/> Process Review (RFE) <input type="checkbox"/> Variance Review <input type="checkbox"/> Follow up <input type="checkbox"/> Foodborne <input type="checkbox"/> 30 Day <input type="checkbox"/> Complaint <input type="checkbox"/> Pre-licensing <input type="checkbox"/> Consultation			Follow up date (if required)	Water sample date/result (if required)

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS																																																																																																							
Mark designated compliance status (IN, OUT, N/O, N/A) for each numbered item: IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable																																																																																																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="background-color: #d3d3d3;">Compliance Status</th> </tr> </thead> <tbody> <tr> <th colspan="2" style="background-color: #d3d3d3;">Supervision</th> </tr> <tr> <td>1 <input checked="" type="checkbox"/> IN <input type="checkbox"/> OUT <input type="checkbox"/> N/A</td> <td>Person in charge present, demonstrates knowledge, and performs duties</td> </tr> <tr> <td>2 <input checked="" type="checkbox"/> IN <input type="checkbox"/> OUT <input type="checkbox"/> N/A</td> <td>Certified Food Protection Manager</td> </tr> <tr> <th colspan="2" style="background-color: #d3d3d3;">Employee Health</th> </tr> <tr> <td>3 <input checked="" type="checkbox"/> IN <input type="checkbox"/> OUT <input type="checkbox"/> N/A</td> <td>Management, food employees and conditional employees; knowledge, responsibilities and reporting</td> </tr> <tr> <td>4 <input checked="" type="checkbox"/> IN <input type="checkbox"/> OUT <input type="checkbox"/> N/A</td> <td>Proper use of restriction and exclusion</td> </tr> <tr> <td>5 <input checked="" type="checkbox"/> IN <input type="checkbox"/> OUT <input type="checkbox"/> N/A</td> <td>Procedures for responding to vomiting and diarrheal events</td> </tr> <tr> <th colspan="2" style="background-color: #d3d3d3;">Good Hygienic Practices</th> </tr> <tr> <td>6 <input type="checkbox"/> IN <input type="checkbox"/> OUT <input checked="" type="checkbox"/> N/O</td> <td>Proper eating, tasting, drinking, or tobacco use</td> </tr> <tr> <td>7 <input checked="" type="checkbox"/> IN <input type="checkbox"/> OUT <input type="checkbox"/> N/O</td> <td>No discharge from eyes, nose, and mouth</td> </tr> <tr> <th colspan="2" style="background-color: #d3d3d3;">Preventing Contamination by Hands</th> </tr> <tr> <td>8 <input type="checkbox"/> IN <input type="checkbox"/> OUT <input type="checkbox"/> N/O</td> <td>Hands clean and properly washed</td> </tr> <tr> <td>9 <input checked="" 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