



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 6, 2025

Licensee
New Journey Residence
100 Vermilion Trail
Biwabik, MN 55708

RE: Project Number(s) SL21987016

Dear Licensee:

On June 10, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 18, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 18, 2024 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 18, 2024, found not corrected at the time of the June 10, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on June 10, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on June 10, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are**

assessed is \$1,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

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 may be imposed immediately with no opportunity to correct the violation first as follows:

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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 Department of Health 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://forms.web.health.state.mn.us/form/HRDAppealsForm>

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.

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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.

Sincerely,

A handwritten signature in black ink that reads "Benjamin Zwart". The signature is written in a cursive style with a large, stylized 'B' and a long, sweeping underline.

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21987	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/10/2025
NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 VERMILION TRAIL BIWABIK, MN 55708			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL21987016-2 On June 5, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 18, 2025. At the time of the survey, there were 27 residents; 27 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and issued.	{0 000}			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action	0 340			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 340	Continued From page 1 taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to take corrective actions related to a citation originally issued on December 17, 2024, and reissued March 18, 2025, to comply with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511. 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 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On June 5, 2025, a revisit to follow-up on orders issued pursuant to a follow up survey completed on March 18, 2025, was completed. Findings include: On a facility tour on June 5, 2025, from 8:00 a.m. to 9:00 a.m., with maintenance (M)-D, the surveyor made the following observations of non-compliance with previously issued citations for non-compliant door locking systems, carbon monoxide detection or alarm systems, smoke alarm maintenance, fire resistant rated door	0 340			

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0 340	Continued From page 2 maintenance, and maintenance of fire-resistant rated ceilings and walls. During an interview on June 5, 2025, at 8:35 a.m., M-D, stated they were working to correct the citations issued at the previous follow up surveys on December 17, 2024, and March 18, 2025, when time permits. No additional information was provided.	0 340			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of	{0 480}			

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{0 480}	Continued From page 3 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 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:	{0 480}	Not reviewed during this survey.		
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	{0 630}			

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{0 630}	Continued From page 4 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}	Not reviewed during this survey.		
{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 information: (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.	{0 650}			

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{0 650}	Continued From page 5	{0 650}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}			

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{0 780}	Continued From page 6 Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 5, 2025, from 8:00 a.m. to 9:00 a.m., with maintenance (M)-D, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: MAGNETICALLY LOCKED EXIT DOORS The exterior exit doors were provided with a magnetic locking system to secure occupants in the building with no emergency release button in an approved location to unlock all doors in the event of a fire or similar emergency. An emergency release button to release all magnetically locked doors is required to be installed at the nurse station, fire command center or other approved location in order to release the doors for the occupants to exit in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules Chapter 7511.	{0 780}			

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{0 780}	Continued From page 7 CARBON MONOXIDE ALARMS/ DETECTION There were carbon monoxide alarms installed on first floor within ten feet of all sleeping rooms but only a local alarm provided in remote locations in the corridors and not within ten feet of all sleeping rooms on second floor. Carbon monoxide detection systems with carbon monoxide detectors installed at the location of the source of carbon monoxide or between the source and the sleeping units are required to be provided with sounding devices at the nurse station or other approved constantly attended location and tied into the fire alarm system. Carbon monoxide alarms or detection systems are required and shall be installed in accordance with MSFC in Minnesota Rules Chapter 7511 and the local fire and building code enforcement official. SMOKE ALARM MAINTENANCE During a facility tour on December 17, 2024, from 11:00 a.m. to 2:45 p.m., with licensed assisted living director (LALD)-A, and maintenance (M)-D, M-D, removed the smoke alarm in resident sleeping room 204 to check manufacture date. The surveyor observed a manufacture date of 1994 stamped into the back of the alarm. It was stated by M-D, that some of the smoke alarms in the building were updated but most were of the same manufacture date from 1994. During an interview on June 5, 2025, at 8:20 a.m., M-D, stated the smoke alarms identified at the previous survey on December 17, 2024, as manufactured in 1994 were replaced within all first floor sleeping units but the second-floor	{0 780}			

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{0 780}	Continued From page 8 smoke alarms have not been replaced. Smoke alarms are required to be replaced every 10 years and maintained according to the product manufacture and MSFC in Minnesota Rules Chapter 7511. FIRE RESISTANT RATED DOOR MAINTENANCE The spring activated self-closing hinges on the fire-resistant rated door of resident sleeping room 201 were not working to close the door automatically. The same door also had a magnetic door hold device installed to hold the door open that was not tied into the alarm to release and close when the alarms are activated. The cross corridor fire-resistant rated doors had the closer arms removed and the doors did not automatically close and latch near resident sleeping rooms 214 and 217. Fire-resistant rated doors installed as part of a fire-resistant rated wall are required to automatically close and latch to prevent the passage of smoke and fire in the event of a for or similar emergency. There was not a closer installed on the fire-resistant rated door of the laundry room in the basement. Fire-resistant rated doors of laundry rooms are required to automatically close and latch to prevent the passage of smoke and fire to the corridor in the event of a for or similar emergency. The door was missing from the opening at the bottom of the exit stairway from the basement near the domestic water heating boiler room. Doors that are part of a fire-resistant rated stair enclosure are required to be maintained and	{0 780}			

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{0 780}	Continued From page 9 automatically close and latch to prevent the passage of smoke and fire to the stairway and corridor in the event of a fire or similar emergency. Multiple door closers were missing on fire-resistant rated doors in the basement. It was also observed that multiple fire-resistant rated doors were propped open in the basement. The exit stairway doors did not automatically close and latch at the upper and lower level of the exit stairway near resident sleeping room 201. Fire-resistant rated doors in stairways are required to automatically close and latch to prevent the passage of smoke into the enclosed stairway. The doors and door frames were removed from the center exit stairway near resident sleeping rooms 112 and 108. Stairways are required to be enclosed with doors that automatically close and latch to prevent the passage of smoke and fire in the event of a fire or similar emergency. MAINTENANCE OF FIRE STOPPING/ CEILINGS There was not a ceiling between floors in the stairway converted to a storage room in the basement under the dining room/ old pool area. There were sections of the ceiling drywall membrane missing in the sprinkler riser room. There were suspended ceiling panels missing in the storage room in the basement near the exit stairway next to the domestic hot water boiler room. The drywall draft stopping in the floor system	{0 780}			

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{0 780}	Continued From page 10 above the domestic hot water boiler in the boiler room was not maintained and sealed to prevent the passage of smoke and fire throughout the floor truss system in the event of a fire or similar emergency. Ceilings and fire stopping are required to be maintained to ensure operation of the sprinkler system and contain fire from spreading to concealed building spaces. Fire sprinkler head placement above and below ceilings is required to comply with MSFC in Minnesota Rules Chapter 7511. MAINTENANCE OF FIRE-RESISTANT RATED WALLS There was a 2-foot by 6-foot unprotected opening into the corridor near the shower room in the basement. Fire-resistant rated corridor walls are required to be maintained and sealed to prevent the passage of smoke and fire to the corridor and concealed building spaces such as the floor joist system. During the facility tour M-D, verified the above listed observations while accompanying on the tour.	{0 780}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	{0 810}			

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{0 810}	Continued From page 11 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	{01060}	Not reviewed during this survey.		

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NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 VERMILION TRAIL BIWABIK, MN 55708		
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{01060}	Continued From page 12 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}			

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{01060}	Continued From page 13	{01060}	Not reviewed during this survey.		
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}			
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all 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;	{01370}			

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{01370}	Continued From page 14 (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}	Not reviewed during this survey.		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:	{01380}			

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{01380}	Continued From page 15 (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this survey.		
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by	{01460}			

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{01460}	Continued From page 16 the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	{01460}	Not reviewed during this survey.		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	{01500}			

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{01500}	Continued From page 17 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	{01500}			

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{01500}	Continued From page 18 access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{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 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:	{01890}			
{01910} SS=D	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,	{01910}			

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{01910}	Continued From page 19 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:	{01910}	Not reviewed during this survey.		
{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. This MN Requirement is not met as evidenced by:	{01960}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 15, 2025

Licensee
New Journey Residence
100 Vermilion Trail
Biwabik, MN 55708

RE: Project Number(s) SL21987016

Dear Licensee:

On March 19, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 18, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 18, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 18, 2024, found not corrected at the time of the March 19, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on March 19, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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 Department of Health 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://forms.web.health.state.mn.us/form/HRDAppealsForm>

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.

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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.

Sincerely,



Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL21987016-1 On March 18, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 18, 2024. At the time of the survey, there were 27 residents; 27 receiving services under the Assisted Living with Dementia Care License. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a 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	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean 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:	{0 480}	Not reviewed during this survey.		
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}			
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records	{0 650}	Not reviewed during this survey.		

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{0 650}	Continued From page 3 (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 information: (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:	{0 650}	Not reviewed during this survey.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	{0 780}			

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{0 780}	Continued From page 4 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 18, 2024, from 1:00 p.m. to 2:30 p.m., with maintenance (M)-D, the surveyor made the following observations of non-compliance with the requirements of the	{0 780}			

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{0 780}	Continued From page 5 Minnesota State Fire Code (MSFC): MAGNETICALLY LOCKED EXIT DOORS The exterior exit doors were provided with a magnetic locking system to secure occupants in the building with no emergency release button in an approved location to unlock all doors in the event of a fire or similar emergency. An emergency release button to release all magnetically locked doors is required to be installed at the nurse station, fire command center or other approved location in order to release the doors for the occupants to exit in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules Chapter 7511. CARBON MONOXIDE ALARMS/ DETECTION There were carbon monoxide alarms with a local alarm only provided in the corridors but there were no carbon monoxide alarms observed within 10 feet of the sleeping rooms. Carbon monoxide detection systems with carbon monoxide detectors installed at the location of the source of carbon monoxide or between the source and the sleeping units are required to be provided with sounding devices at the nurse station or other approved constantly attended location. Carbon monoxide alarms or detection systems are required and shall be installed in accordance with MSFC in Minnesota Rules Chapter 7511 and the local fire and building code enforcement official.	{0 780}			

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{0 780}	Continued From page 6 SMOKE ALARM MAINTENANCE During a facility tour on December 17, 2024, from 11:00 a.m. to 2:45 p.m., with licensed assisted living director (LALD)-A, and maintenance (M)-D, M-D, removed the smoke alarm in resident sleeping room 204 to check manufacture date. The surveyor observed a manufacture date of 1994 stamped into the back of the alarm. It was stated by M-D, that some of the smoke alarms in the building were updated but most were of the same manufacture date from 1994. During an interview on March 18, 2025, at 1:30 p.m., M-D, stated the smoke alarms identified at the previous survey on December 17, 2024, as manufactured in 1994 were not replaced with new updated smoke alarms. Smoke alarms are required to be replaced every 10 years and maintained according to the product manufacture and MSFC in Minnesota Rules Chapter 7511. MECHANICAL EQUIPMENT VENT CLEARANCE The domestic hot water boiler vent single wall pipe had a clearance to combustible floor joists of eight inches and limited clearance to combustibles at the through wall penetration to the exterior. The boiler vent was also provided with a mechanical draft vent system that had no clearance to combustible floor joists. Fuel fired gas appliance vents shall be installed with the required vent materials and clearance to combustibles according to manufactures instructions, MSFC in Minnesota Rules Chapter 7511 and Minnesota Mechanical and Fuel Gas Code in Minnesota Rules Chapter 1346 to reduce	{0 780}			

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{0 780}	Continued From page 7 the risk of fire by extended exposure of the vent to combustible materials. Verify with local fire and building code authority that the clearances and vent materials meet the requirements of the codes stated and manufactures installation instructions. FIRE RESISTANT RATED DOOR MAINTENANCE The spring activated self-closing hinges on the fire-resistant rated door of resident sleeping room 201 were not working to close the door automatically. The same door also had a magnetic door hold device installed to hold the door open that was not tied into the alarm to release and close when the alarms are activated. The cross corridor fire-resistant rated doors had the closer arms removed and the doors did not automatically close and latch near resident sleeping rooms 214 and 217. Fire-resistant rated doors installed as part of a fire-resistant rated wall are required to automatically close and latch to prevent the passage of smoke and fire in the event of a for or similar emergency. There was not a closer installed on the fire-resistant rated door of the laundry room in the basement. Fire-resistant rated doors of laundry rooms are required to automatically close and latch to prevent the passage of smoke and fire to the corridor in the event of a for or similar emergency. The door was missing from the opening at the bottom of the exit stairway from the basement near the domestic water heating boiler room. Doors that are part of a fire-resistant rated stair enclosure are required to be maintained and automatically close and latch to prevent the	{0 780}			

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{0 780}	Continued From page 8 passage of smoke and fire to the stairway and corridor in the event of a fire or similar emergency. Multiple door closers were missing on fire-resistant rated doors in the basement. It was also observed that multiple fire-resistant rated doors were propped open in the basement. The exit stairway doors did not automatically close and latch at the upper and lower level of the exit stairway near resident sleeping room 201. Fire-resistant rated doors in stairways are required to automatically close and latch to prevent the passage of smoke into the enclosed stairway. The doors and door frames were removed from the center exit stairway near resident sleeping rooms 112 and 108. Stairways are required to be enclosed with doors that automatically close and latch to prevent the passage of smoke and fire in the event of a fire or similar emergency. MAINTENANCE OF FIRE STOPPING/ CEILINGS There was not a ceiling between floors in the stairway converted to a storage room in the basement under the dining room/ old pool area. There were sections of the ceiling drywall membrane missing in the sprinkler riser room. There were suspended ceiling panels missing in the storage room in the basement near the exit stairway next to the domestic hot water boiler room. The drywall draft stopping in the floor system	{0 780}			

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{0 780}	Continued From page 9 above the domestic hot water boiler in the boiler room was not maintained and sealed to prevent the passage of smoke and fire throughout the floor truss system in the event of a fire or similar emergency. Ceilings and fire stopping are required to be maintained to ensure operation of the sprinkler system and contain fire from spreading to concealed building spaces. Fire sprinkler head placement above and below ceilings is required to comply with MSFC in Minnesota Rules Chapter 7511. MAINTENANCE OF FIRE-RESISTANT RATED WALLS There was a 2-foot by 6-foot unprotected opening into the corridor near the shower room in the basement. Fire-resistant rated corridor walls are required to be maintained and sealed to prevent the passage of smoke and fire to the corridor and concealed building spaces such as the floor joist system. During the facility tour M-D, verified the above listed observations while accompanying on the tour.	{0 780}			
{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	{0 800}			

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{0 800}	Continued From page 10 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, 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, 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: On a facility tour on March 18, 2024, from 1:00 p.m. to 2:30 p.m., with maintenance (M)-D, the surveyor made the following observations of facility disrepair: CEILING WATER DAMAGE The ceiling had a four-foot square area of water damage in the basement corridor outside the domestic hot water boiler room. During an interview on March 18, 2025, at 1:50 p.m., M-D, stated the water staining on the ceiling was caused by water infiltration under the exterior door and stoop in that area above the corridor.	{0 800}			

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{0 800}	Continued From page 11 M-D, also stated during the interview that the repair of the staining was not completed and would be completed with repair of the other ceilings requiring repair. During the facility tour M-D, verified the above listed observations while accompanying on the tour.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill	{0 810}			

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{0 810}	Continued From page 12 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	{01060}			

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{01060}	Continued From page 13 (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.		
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	{01290}			

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{01290}	Continued From page 14	{01290}	Not reviewed during this survey.		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all 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;	{01370}			

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{01370}	Continued From page 15 (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}	Not reviewed during this survey.		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}			
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors	{01460}	Not reviewed during this survey.		

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{01460}	Continued From page 16 (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	{01460}	Not reviewed during this survey.		

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{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	{01500}			

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{01500}	Continued From page 18 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{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 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:	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	{01910}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 VERMILION TRAIL BIWABIK, MN 55708			
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{01910}	Continued From page 19 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:	{01910}	Not reviewed during this survey.		
{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 20 This MN Requirement is not met as evidenced by:	{01960}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 10, 2025

Licensee
New Journey Residence
100 Vermilion Trail
Biwabik, MN 55708

RE: Project Number(s) SL21987016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in dark ink, reading "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21987	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2024
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0 000	Initial Comments 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: SL219872016-0 On December 16, 2024, through December 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 27 residents; 27 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a 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	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 18, 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	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R2, 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 potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 16,	0 630			

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0 630	Continued From page 4 2024, at 10:47 to 11:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R1 R1's diagnoses included bipolar disorder, diabetes, below the knee amputation of right lower leg, and hypertension (high blood pressure). R1's Service Plan dated October 29, 2024, indicated R1 received assistance with medication management, bathing, dressing, grooming, skin cares, transfers, bed mobility, toileting, housekeeping, laundry, and shopping. On December 17, 2024, at 6:42 a.m., the surveyor observed licensed practical nurse (LPN)-G monitoring R1's blood glucose (sugar) and inject 12 units of Fiasp (fast-acting) insulin into R1's right abdomen. R2 R2's diagnoses included adult failure to thrive, hypertension, left tibia fracture, muscle weakness and osteoarthritis (degenerative joint disease). R2's Service Plan dated January 29, 2024, indicated R2 received assistance with medication management, bathing, meals, housekeeping, and laundry. R3 R3's diagnoses included depression, chronic obstructive pulmonary disease (COPD), and diabetes type II. R3's Service Plan dated November 8, 2024, indicated R3 received assistance with meals and	0 630			

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0 630	Continued From page 5 housekeeping. R1, R2 and R3's Vulnerability, Safety and Risk assessments dated August 29, 2024, December 13, 2024, and November 22, 2024, respectively, lacked an individual assessment of the resident's susceptibility to abuse by other individuals. On December 18, 2024, at 10:38 a.m., CNS-B reviewed the licensee's Vulnerability, Safety and Risk assessment and stated the assessment did not include a review of a resident's susceptibility to abuse by others and would have the question added to the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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 information: (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	0 650			

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0 650	Continued From page 6 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 observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of three employees (unlicensed personnel (ULP)-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E had a hire date of June 11, 2024, to provide direct care services to the licensee's residents. R1's November 2024 Service Delivery record included ULP-E's signature indicating ULP-E assisted R1 with dressing, grooming, transferring, toileting, and blood pressure monitoring. ULP-E's employee record indicated ULP-E completed the required training; however,	0 650			

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0 650	Continued From page 7 ULP-E's employee record did not include evidence ULP-E demonstrated competencies in the following required areas: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them -reading and recording temperature, pulse, and respirations of the client -safe transfer techniques and ambulation; and -range of motioning and positioning. ULP-F ULP-F had a hire date of October 1, 2015, to provide direct care services to the licensee's residents. ULP-F's employee record included competencies in medication administration; however, lacked evidence ULP-F had been trained and had demonstrated competency to provide medications to residents for unplanned times away from the facility. On December 18, 2024, at 2:28 p.m., clinical nurse supervisor (CNS)-B stated staff were trained during new employee orientation on how to prepare medications for residents who leave the facility, and the procedure was in the electronic medical records for staff to follow. CNS-B stated over the years the training forms have been changed and ULP-F's training forms did not include unplanned time away training. CNS-B stated ULP-E's employee records did not include competency evaluations for the above trainings noted above.	0 650			

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0 650	Continued From page 8 The licensee's undated Training, Competency and Orientation of Unlicensed Personnel policy indicated all unlicensed professionals would demonstrate competency through either a written or oral exam of skill areas as followed by a practical demonstration of skills area. Training and competency evaluations for all unlicensed personnel must include the following: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them -reading and recording temperature, pulse, and respirations of the client -safe transfer techniques and ambulation; and -range of motioning and positioning. Record of competency demonstration would be kept in personnel records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780			

Minnesota Department of Health

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0 780	Continued From page 9 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on December 17, 2024, from 11:00 a.m. to 2:45 p.m., with licensed assisted living director (LALD)-A, and maintenance (M)-D, the surveyor made the following observations of	0 780			

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0 780	Continued From page 10 non-compliance with the requirements of the Minnesota State Fire Code (MSFC): OPEN HEATING FUEL GAS LINE There was an open gas line without a cap or plug to protect heating fuel gas from entering the building in the event the inline valve is turned on where the clothes dryer was removed in the laundry room. In order to prevent fire or explosion heating fuel gas lines are required to have a cap or plug installed at the open end of the pipe to prevent heating fuel gas from entering the building in the event the inline valve is accidentally opened in accordance with Minnesota Mechanical and Fuel Gas Code in Minnesota Rules Chapter 1346. MAGNETICALLY LOCKED EXIT DOORS The exterior exit doors were provided with a magnetic locking system to secure occupants in the building with no emergency release button in an approved location to unlock all doors in the event of a fire or similar emergency. During record review on December 17, 2024, the Fire Safety and Evacuation Plan (FSEP) lacked the procedures to unlock the magnetically locked exit doors for the purpose of exiting in the event of a fire or similar emergency. An emergency release button to release all magnetically locked doors is required to be installed at the nurse station, fire command center or other approved location in order to release the doors for the occupants to exit in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules	0 780			

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0 780	Continued From page 11 Chapter 7511. The FSEP is required to include procedures to operate and unlock the magnetically locked door system in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules Chapter 7511. CARBON MONOXIDE ALARMS/ DETECTION There were carbon monoxide alarms with a local alarm only provided in the corridors but there were no carbon monoxide alarms observed within 10 feet of the sleeping rooms. Carbon monoxide alarms or detection systems are required and shall be installed in accordance with MSFC in Minnesota Rules Chapter 7511 and the local fire and building code enforcement official. SMOKE ALARM MAINTENANCE During the tour M-D, removed the smoke alarm in resident sleeping room 204 to check manufacture date. The surveyor observed a manufacture date of 1994 stamped into the back of the alarm. It was stated by M-D, that some of the smoke alarms in the building were updated but most were of the same manufacture date from 1994. Smoke alarms are required to be replaced every 10 years and maintained according to the product manufacture and MSFC in Minnesota Rules Chapter 7511. MARKED EXIT MAINTENANCE There was a marked exit from the dining room through the kitchen with a keyed lock installed on	0 780			

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0 780	Continued From page 12 the egress side and another marked exit from the kitchen to the exterior with a chain security lock installed near the head jamb. During the tour M-D, stated the door from the dining room is locked after kitchen hours. Occupants shall not be directed through a kitchen to exit as it is a higher hazard area than the dining room space. Marked exit doors are required to be openable from the egress (inside) with one operation and shall not require the use of keys, tools, or special knowledge. MECHANICAL EQUIPMENT VENT CLEARANCE The domestic hot water boiler vent single wall pipe had a clearance to combustible floor joists of eight inches and no clearance to combustibles at the through wall penetration to the exterior. The boiler vent was also provided with a mechanical draft vent system that had no clearance to combustible floor joists. Fuel fired gas appliance vents shall be installed with the required vent materials and clearance to combustibles according to manufactures instructions, MSFC in Minnesota Rules Chapter 7511 and Minnesota Mechanical and Fuel Gas Code in Minnesota Rules Chapter 1346 to reduce the risk of fire by extended exposure of the vent to combustible materials. FIRE RESISTANT RATED DOOR MAINTENANCE The spring activated self-closing hinges on the fire-resistant rated door of resident sleeping room 201 were not working to close the door automatically. The same door also had a magnetic door hold device installed to hold the	0 780			

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0 780	Continued From page 13 door open that was not tied into the alarm to release and close when the alarms are activated. The cross corridor fire-resistant rated doors had the closer arms removed and the doors did not automatically close and latch near resident sleeping rooms 214 and 217. Fire-resistant rated doors installed as part of a fire-resistant rated wall are required to automatically close and latch to prevent the passage of smoke and fire in the event of a for or similar emergency. There was not a closer installed on the fire-resistant rated door of the laundry room in the basement. Fire-resistant rated doors of laundry rooms are required to automatically close and latch to prevent the passage of smoke and fire to the corridor in the event of a for or similar emergency. The door was missing from the opening at the bottom of the exit stairway from the basement near the domestic water heating boiler room. Doors that are part of a fire-resistant rated stair enclosure are required to be maintained and automatically close and latch to prevent the passage of smoke and fire to the stairway and corridor in the event of a fire or similar emergency. Multiple door closers were missing on fire-resistant rated doors in the basement. It was also observed that Multiple fire-resistant rated doors were propped open in the basement. The exit stairway doors did not automatically close and latch at the upper and lower level of the exit stairway near resident sleeping room 201. Fire-resistant rated doors in stairways are required to automatically close and latch to	0 780			

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0 780	Continued From page 14 prevent the passage of smoke into the enclosed stairway. The doors and door frames were removed from the center exit stairway near resident sleeping rooms 112 and 108. Stairways are required to be enclosed with doors that automatically close and latch to prevent the passage of smoke and fire in the event of a fire or similar emergency. MAINTENANCE OF FIRE STOPPING/ CEILINGS There was not a ceiling between floors in the stairway converted to a storage room in the basement under the dining room/ old pool area. There were sections of the ceiling drywall membrane missing in the sprinkler riser room. There were suspended ceiling panels missing in the storage room in the basement near the exit stairway next to the domestic hot water boiler room. The ceiling was open to the floor truss system on the side of the room over the door entering the domestic hot water boiler room. Ceilings and fire stopping are required to be maintained to ensure operation of the sprinkler system and contain fire from spreading to concealed building spaces. Fire sprinkler head placement above and below ceilings is required to comply with MSFC in Minnesota Rules Chapter 7511. MAINTENANCE OF FIRE-RESISTANT RATED WALLS	0 780			

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0 780	Continued From page 15 There was a hole through the fire-resistant wall drywall membrane near the ceiling in the center stairway near resident rooms 112 and 108. There was a 2-foot by 6-foot unprotected opening into the corridor near the shower room in the basement. Fire-resistant rated corridor walls are required to be maintained and sealed to prevent the passage of smoke and fire to the corridor and concealed building spaces such as the floor joist system. OPEN EXPOSED ELECTRICAL CONNECTIONS There were open electrical boxes and connections in the domestic hot water boiler room, and the storage room converted from a stairway in the basement below the dining room. There was a wall outlet not secured in the electrical box without a cover powering the air compressor in the sprinkler riser room. The surveyor explained to M-D, that electrical connections are required to be completed inside electrical boxes and covers are required to be installed on the box. EXIT ACCESS DOOR LOCKS There was a security lock installed on the non-egress (outside) side of the barn style sliding door near resident sleeping room 120. The surveyor explained to LALD-A, and M-D, that all rooms and spaces are required to be provided with at least one exit operable from the egress (inside) without the use of keys, tools, or special knowledge.	0 780			

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0 780	Continued From page 16 STORAGE IN EXIT STAIRWAY There was storage of garbage cans and linen containers at the upper and lower level of the exit stairway near resident sleeping room 201. Exit stairways and corridors are required to be maintained clear of combustible materials and obstructions that prevent full and immediate use for exiting during a fire or similar emergency. During the facility tour LALD-A, and M-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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	0 800			

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0 800	Continued From page 17 to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 17, 2024, from 11:00 a.m. to 2:45 p.m., with licensed assisted living director (LALD)-A, and maintenance (M)-D, the surveyor made the following observations of facility disrepair: DOMESTIC HOT WATER SUPPLY The domestic water heating boiler and hot water storage tank were not working to supply domestic hot water to the building because of a leak in the piping system in the boiler room. During an interview on December 17, 2024, at 10:30 a.m., M-D, stated the boiler piping in the boiler room was leaking and the system had to be shut down so repairs could be completed. During the same interview M-D, also stated a contractor was hired, parts were ordered, and the repair were scheduled to be completed December 18, 2024. CEILING WATER DAMAGE The ceiling had a four-foot square area of water damage in the basement corridor outside the	0 800			

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0 800	Continued From page 18 domestic hot water boiler room. During an interview on December 17, 2024, at 2:15 p.m., M-D, stated the water staining on the ceiling was caused by water infiltration under the exterior door and stoop in that area above the corridor. OPEN DOMESTIC WATER LINE There was an open domestic water line in the first-floor corridor without a cap or plug to prevent water flow into the corridor in the event the inline valve was inadvertently turned on. The surveyor explained to LALD-A, and M-D, that open water lines are required to be provided with a plug or cap to prevent inadvertent water flow into the occupied space. During a facility tour on December 17, 2024, LALD-A, and M-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810			

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0 810	Continued From page 19 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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).	0 810			

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0 810	Continued From page 20 The findings include: On December 17, 2024, at 10:15 a.m., licensed assisted living director (LALD)-A, and maintenance (M)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on December 17, 2024, at 10:20 a.m., LALD-A, stated documentation of procedures for residents to take in the event of a fire or similar emergency were not provided in writing in the FSEP and were given to residents orally at resident council meetings. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by not providing documentation the required employee training was provided separate and in addition to evacuation drills. During an interview on December 17, 2024, at 10:25 a.m., M-D, stated the required employee training was provided verbally during the	0 810			

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0 810	Continued From page 21 evacuation drills but was not documented separate and in addition to the drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative;	01060			

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01060	Continued From page 22 (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and/or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for two of two residents (R1, R2) reviewed for a hospitalization. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included bipolar disorder, diabetes, below the knee amputation of right	01060			

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01060	Continued From page 23 lower leg, and hypertension (high blood pressure). R1's Service Plan dated October 29, 2024, indicated R1 received assistance with medication management, bathing, dressing, grooming, skin cares, transfers, bed mobility, toileting, housekeeping, laundry, and shopping. R1's progress notes dated September 6, 2024, indicated R1 requested to be sent to the emergency room and was admitted to the hospital for pneumonia. R1's progress notes dated September 8, 2024, indicated R1 returned from the hospital. R2 R2's diagnoses included adult failure to thrive, hypertension, left tibia fracture, muscle weakness and osteoarthritis (degenerative joint disease). R2's Service Plan dated January 29, 2024, indicated R2 received assistance with medication management, bathing, meals, housekeeping, and laundry. R2's progress notes dated October 27, 2024, indicated licensed practical nurse (LPN)-G received a call from the hospital and was informed R2 was admitted due to a drop on oxygen saturation level and would be staying in the hospital over the weekend. R2's progress notes dated October 31, 2024, indicated R2 was discharged from the hospital and admitted to another facility for rehabilitation. R2's progress notes dated December 13, 2024, indicated R2 was readmitted to the facility	01060			

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01060	Continued From page 24 following a hospitalization and rehabilitation stay. R1 and R2's record lacked evidence a written notice, including the following required content was provided to R1 or R2's representative: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification was provided to the Office of Ombudsman for Long-Term Care for R2's hospitalization of four days or longer: In addition, R2's record lacked notification was provided to the Office of Ombudsman for Long-Term Care for R2's hospitalization of four days or longer. On December 17, 2024, 1:06 p.m., clinical nurse supervisor (CNS)-B stated she was unaware of the requirement and only notified the resident's county case manager of hospitalizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21987	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 VERMILION TRAIL BIWABIK, MN 55708			
(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
01060	Continued From page 25 (21) days	01060			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure background studies (BGS) were submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of eight employees (licensed practical nurse (LPN)-J) and one of two on-call employees (registered nurse (RN)-I). This had the potential to affect all 27 residents. 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	01290			

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NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 VERMILION TRAIL BIWABIK, MN 55708		
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01290	Continued From page 26 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: During entrance conference on December 16, 2024, 10:47 a.m., to 11:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee employed three licensed staff; however, shared on-call with other RNs who worked at other assisted living locations managed by the same company. On December 16, 2024, at 2:16 p.m., CNS-B provided the surveyor the licensee's employee roster. CNS-B stated RN-I was not included on the employee roster as they were hired to work at another assisted living location managed by the same company. CNS-B stated RN-I only participated with on-call RN services via telephone for the licensee and did not work at the facility. On December 16, 2024, at 2:42 p.m., licensed assisted living director (LALD)-A reviewed the licensee's NetStudy employee roster with the surveyor and stated RN-I and LPN-J were not listed on the on the licensee's NetStudy roster nor had been affiliated with the licensee's HFID 21987. LALD-A stated they did not know why LPN-J were not listed on the licensee's NetStudy roster and should have been. LALD-A stated RN-I was hired to work at another assisted living owned by the same company and was unaware the on-call RNs were required to be affiliated with each assisted living's HFID even if they just provided on-call services. LPN-J	01290			

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01290	Continued From page 27 LPN- J had a hire date of May 13, 2016, to provide direct services and supervision to the licensee's residents and was licensed on June 25, 2019. LPN-J's BGS Clearance letter dated January 3, 2022, was cleared; however, was affiliated with HFID 20846 and not affiliated to the licensee's assisted living HFID 21987. RN-I RN-I had a hire date of March 26, 2024, at another assisted living location managed by the same company and was licensed on July 29, 1999. RN-I's background check dated May 13, 2022, indicated RN-I's background checked was determined eligible; however, had not been affiliated with the licensee's HFID 21787 until December 18, 2024, after the surveyor requested the licensee's NetStudy employee roster. On December 18, 2024, at 9:01 a.m., LALD-A stated they updated the Department of Human Services (DHS) NetStudy employee roster and affiliated the employees noted above to the licensee HFID 21987 December 17, 2024, which had not been previously affiliated. The licensee's undated Background Study Policy, indicated the licensee would conduct a Minnesota Department of Human Services the Background Study on all employees, volunteers, and contractors of the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

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01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all 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	01370			

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01370	Continued From page 29 technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of three employees (unlicensed personal (ULP)-C). This had the potential to affect all 27 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on December 16, 2024, from 10:47 a.m., to 11:45 a.m., clinical nurse supervisor (CNS)-B stated employee training was a collaborative effort with licensed assisted living director (LALD)-A. CNS-B stated new hired ULPs would work alongside other ULPs to learn resident care plans, and get hands on experience in providing resident personal cares, transfers, and administering medications and treatments. CNS-B stated after the new ULP obtained experience working alongside other ULPs, CNS-B would complete competency evaluations with the new hired ULPs on administering medications, delegated tasks and treatments. ULP-C was re-hired on November 15, 2024, to	01370			

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01370	Continued From page 30 provide direct care services to residents of the facility. R2 and R3's December 2024, medication administration records (MAR) included ULP-D's initials indicating ULP-D administered R2 and R3's scheduled morning medications. ULP-C's employee record included training transcripts with assigned courses from ULP-C's previous employment dated July 9, 2019; however, ULP-C's employee record did not include evidence ULP-C was retrained and received the following required training and/or competencies after ULP-C left employment for two years and was rehired under the licensee assisted living license in 2024 to include: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. -training on the prevention of falls for providers working with the elderly or those at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; -basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating; -communication skills that include preserving the	01370			

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01370	Continued From page 31 dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff, residents and the resident's family; and -procedures to utilize in handling various emergency situations Awareness of commonly used health technology equipment and assistive devices. On December 16, 2024, at 4:14 p.m., during a telephone interview, ULP-C stated when she was rehired by the licensee, she worked alongside of other ULPs and was not required to complete training on medications or treatments before providing care and services to the licensee's residents. ULP-C stated on ULP-C's first day working independently, CNS-B observed ULP-C administer resident medications. On December 17, 2024, at 12:32 p.m., CNS-B sated ULP-C did not complete the required training or demonstrated competency before providing care and services to the licensee's residents. On December 18, 2024, at 9:45 a.m., LALD-A stated ULP-C had not worked for the licensee since September 27, 2022, and was rehired November 15, 2024. LALD-A stated ULP-C had not worked for the licensee in the past two years and should have received the required training and competencies in the topics noted above when ULP-C was rehired. The licensee's undated Training, Competency and Orientation of Unlicensed Personnel policy indicated all unlicensed professionals would demonstrate competency through either a written	01370			

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01370	Continued From page 32 or oral exam of skill areas as followed by a practical demonstration of skills area. Training and competency evaluations for all unlicensed personnel must include the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. -training on the prevention of falls for providers working with the elderly or those at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; -basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating; -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; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff, residents and the resident's family; and -procedures to utilize in handling various emergency situations Awareness of commonly used health technology equipment and assistive devices. No further information was provided.	01370			

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01370	Continued From page 33	01370			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of three employees (unlicensed personal (ULP)-C). This had the potential to affect all 27 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	01380			

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01380	Continued From page 34 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: During entrance conference on December 16, 2024, from 10:47 a.m., to 11:45 a.m., clinical nurse supervisor (CNS)-B stated employee training was a collaborative effort with licensed assisted living director (LALD)-A. CNS-B stated new hired ULPs would work alongside other ULPs to learn the resident care plan, and get experience in providing resident personal cares, transfers, and administering medications and treatments. CNS-B stated after the new ULP obtained experience working alongside other ULPs, CNS-B would complete competency evaluations with the new hired ULPs on administering medications, delegated tasks and treatments. ULP-C was re-hired on November 15, 2024, to provide direct care services to residents of the facility. R2 and R3's December 2024, medication administration records (MAR) included ULP-D's initials indicating ULP-D administered R2 and R3's scheduled morning medications. ULP-C's employee record included training transcripts with assigned courses from ULP-C's previous employment dated July 9, 2019; however, ULP-C's employee record did not include evidence ULP-C was retrained and received the following required training and/or competencies after ULP-C left employment for two years and was rehired under the licensee assisted living license in 2024 to include:	01380			

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01380	Continued From page 35 -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the client; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On December 16, 2024, at 4:14 p.m., during a telephone interview, ULP-C stated when she was rehired by the licensee, she worked alongside of other ULPs and was not required to complete training on medications or treatments before providing care and services to the licensee's residents. ULP-C stated on ULP-C's first day working independently, CNS-B observed ULP-C administer resident medications. On December 17, 2024, at 12:32 p.m., CNS-B sated ULP-C did not complete the required training or demonstrated competency before providing care and services to the licensee's residents. On December 18, 2024, at 9:45 a.m., LALD-A stated ULP-C had not worked for the licensee since September 27, 2022, and was rehired November 15, 2024. LALD-A stated ULP-C had not worked for the licensee in the past two years and should have received the required training	01380			

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01380	Continued From page 36 and competencies in the topics noted above when ULP-C was rehired. The licensee's undated Training, Competency and Orientation of Unlicensed Personnel policy indicated all unlicensed professionals would demonstrate competency through either a written or oral exam of skill areas as followed by a practical demonstration of skills area. Training and competency evaluations for all unlicensed personnel must include the following: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the client; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted	01460			

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01460	Continued From page 37 living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing direct services completed orientation to assisted living facility licensing requirements and regulations before providing services for one of three	01460			

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01460	Continued From page 38 employees (unlicensed personnel (ULP)-C). This had the potential to affect all residents. 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: During entrance conference on December 16, 2024, from 10:47 a.m. to 11:45 a.m., clinical nurse supervisor (CNS)-B stated employee training was a collaborative effort with licensed assisted living director (LALD)-A. LALD-A stated LALD-A was responsible for maintaining employee records and was aware of the required content for employee records. ULP-C was previously employed by the licensee from July 13, 2019, to September 27, 2022. ULP-C was re-hired November 15, 2024, to provide direct care services to the licensee's residents. R1's December 2024, medication administration records (MAR) and service delivery record included ULP-C's initials indicating ULP-C administered R1's scheduled medications and provided assistance with dressing, grooming, toileting, transfers, mobility and ambulation. ULP-C's employee record included an Employee Orientation Checklist; however, lacked name and authentication of the employee, the evaluator, and date verifying ULP-C completed orientation to	01460			

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01460	Continued From page 39 assisted living requirements at the time of re-hire to include: -an overview of chapter 144G.08 through 144G.93; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. During a telephone interview on December 16, 2024, at 4:14 p.m., ULP-C stated ULP-C previously worked for the licensee two years ago and was re-hired November 2024. ULP-C stated they were assigned training course in Care	01460			

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01460	Continued From page 40 Academy (electronic training program) and ULP-C had not completed any required trainings before working with resident including orientation to assisted living requirements and ULP-C-C had one year to complete assigned courses. On December 17, 2024, at 12:32 p.m., CNS-B stated required training courses had been assigned to ULP-C through Care Academy; however, ULP-C had not completed the required trainings noted above before providing services to the licensee's residents upon re-hire. CNS-B stated since ULP-C previously worked for the licensee and received training under the licensee's previous comprehensive license in July 2019, Care Academy did not recognized ULP-C as a new employee and was only required to complete annual training. CNS-B verified ULP-C's Employee Orientation Checklist did not include a signature from ULP-C, the name and title of the evaluator or a date orientation to assisted living training had been completed. On December 18, 2024, at 10:08 a.m., LALD-A stated ULP-C should have been treated like a new employee and receive all required orientation training since ULP-C had not worked for the licensee in over two years. The licensee's undated New Employee Orientation Policy indicated upon hire and prior to performing any functions of their position at [licensee's name], each new employee would be oriented in accordance with State and Federal regulations, as well as company policy and procedure. An orientation checklist would be completed by the employee and trainer, signed by each person, and would be filed in the employee's record.	01460			

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01460	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	01500			

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01500	Continued From page 42 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees performing direct services completed the required annual training for one of two employees (unlicensed personnel (ULP)-F). This had the potential to affect all 27 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	01500			

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01500	Continued From page 43 has affected or has the potential to affect a large portion or all of the residents). The findings include:: During entrance conference on December 16, 2024, from 10:47 a.m., to 11:45 a.m., clinical nurse supervisor (CNS)-B stated , licensed assisted living director (LALD)-A stated LALD-A was responsible for maintaining employee records and CNS-B was primarily responsible for employee training. ULP-F had a hire date October 1, 2015, to provide direct care services to the residents of the facility. On December 17, 2024, at 6:57 a.m., the surveyor observed ULP-F assist R1 with personal cares and dressing. ULP-F's employee record lacked evidence ULP-F successfully completed annual training as required to include: -review of provider's policies and procedures; and -principles of person-centered planning/service delivery. On December 18, 2024, at 2:28 p.m., clinical nurse supervisor (CNS)-B reviewed ULP-F employee training records and stated employees have access to the provider's policies and procedures, and they do not document annual review in the employee records. CNS-B stated ULP-F's employee record did not include ULP-F completed annual training in person-centered planning/service delivery. The licensee's undated Annual Required Staff Training policy indicated training record, would be	01500			

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01500	Continued From page 44 kept in employee records, and would be retained for each employee who performs direct care services to track compliance with annual training requirements. All staff that perform direct care services to the licensee's residents would complete at least eight hours of annual training for each 12 months of employment to include: -a review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -principle of person-centered planning and service delivery and how they apply to direct support services provided by staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
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 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 ensure medications were maintained and monitored for expired dates when stored by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890			

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01890	Continued From page 45 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: During entrance conference on December 16, 2024, at 10:47 to 11:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to include medication storage. On December 16, 2024, at 12:26 p.m., CNS-B stated the licensed practical nurse (LPN) monitored the medication carts weekly checking for expired medications. The surveyor observed the South and North medication storage carts with CNS-B. CNS-B confirmed the following: South Medication Cart -one opened bottle of stock milk of magnesium (used to treat constipation) had expired November 11, 2024; and -R5's opened bottle of mineral oil was filled by the pharmacy November 22, 2021, and had expired November 2022. North Medication Cart -one opened bottle of stock Geri Tussin DM (cough medicine) had expired October 2024; and -R6's opened bottle of acetaminophen (pain reliever) 325 milligrams (mg) had expired March 2024. The licensee's Storage of Medication policy	01890			

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01890	Continued From page 46 undated, indicated the licensee would safely and securely store medications managed by the licensee; and medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	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 document in the resident's record the required content on disposition of the	01910			

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01910	Continued From page 47 medications for one of one resident (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) 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: During the entrance conference on December 16, 2024, at 10:47 to 11:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R2 diagnoses included adult failure to thrive, hypertension (high blood pressure), and left tibia fracture. R2's Service Plan dated January 29, 2024, indicated R2 received medication management services. R2's progress notes dated December 13, 2024, indicated R2 was readmitted to the facility post hospital stay and the following medications were discontinued and returned to the pharmacy for destruction: -rosuvastatin 14 tablets (used to lower high cholesterol) with prescription number 981420; -atorvastatin 30 tablets (used to lower high cholesterol) with prescription number 9841420; - and -Tylenol 350 tablets (pain reliever) with prescription number 972130.	01910			

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01910	Continued From page 48 R2's record lacked documentation for the disposition of medications to include the dosages of the medications given to the pharmacy for destruction. On December 18, 2024, at 1:25 p.m., CNS-B stated they do not complete a separate medication destruction sheet for destroyed medications and document resident's destroyed or returned medications in the resident progress notes. CNS-B confirmed R2's record did not include the dosages of R2's medications that were returned to the pharmacy for destruction and was aware of the requirement. The licensee's Medication Disposal policy undated, indicated upon disposition, the licensee would document the following in the resident record: -the medication name, strength, prescription number of medications, as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
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	01960			

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01960	Continued From page 49 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a resident treatment plan was followed for one of one resident (R1) who received blood glucose monitoring. 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: During entrance conference on December 16, 2024, at 10:47 to 11:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to include blood glucose (sugar) monitoring. R1's diagnoses included diabetes. R1's physician orders dated September 26, 2024, included blood glucose monitoring before meals and at bedtime. R1's quarterly assessment dated August 29, 2024, indicated R1 required blood glucose	01960			

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01960	Continued From page 50 monitoring four times a day. R1's Service Plan dated November 1, 2024, included blood glucose monitoring. The service plan directed staff to check R1's blood glucose four times and day and as needed for symptoms and to notify licensed staff if R1's blood glucose was less than 60 mg/dl or over 350 milligrams per deciliter (mg/dl). On December 17, 2024, at 6:42 a.m., the surveyor observed licensed practical nurse (LPN)-G monitoring R1's blood glucose with results of 170 mg/dl. R1's blood glucose report dated November 1, 2024, to December 16, 2024, indicated R1's blood glucose values were over 350 mg/dl on the following dates: -On December 16, at 5:21 p.m., blood glucose result of 379 mg/dl; -On December 13, at 11:21 a.m., blood glucose result of 393 mg/dl; -On December 12, at 11:27 a.m., blood glucose result of 367 mg/dl; -On November 28, at 4:33 p.m., blood glucose result of 400 mg/dl; and -On November 17, at 11:10 a.m., blood glucose result of 369 mg/dl. R1's Progress notes dated November 1, 2024, to December 16, 2024, lacked documentation licensed staff had been notified of the above noted blood glucose readings over 350 mg/dl as directed and any directions given. On December 17, 2024, at 1:49 p.m., CNS-B stated staff have notified her of R1's blood glucose readings over 350 mg/dl and CNS-B would direct staff to administer R1's sliding scale	01960			

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01960	Continued From page 51 insulin dose as directed. CNS-B stated staff should be documenting in R1's record if the nurse had been notified and any directions given. CNS-B stated she was unable to find any documentation in R1's record the nurse had been notified of R1's blood glucose readings above 350 mg/dl and any directions given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			

Type: Full
Date: 12/17/24
Time: 10:00:00
Report: 1006241182

Food and Beverage Establishment Inspection Report

Page 1

Location:

New Journey Residence
100 Vermilion Trail
Biwabik, MN55708
St. Louis County, 69

Establishment Info:

ID #: 0038664
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188654588
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

4-302.14

**** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

STAFF USE BLEACH WATER, BUT DO NOT HAVE THE APPROPRIATE TEST STRIPS TO CHECK THE LEVELS. PROVIDE CHLORINE TEST STRIPS TO HELP ENSURE PROPER LEVELS, 50-200 PPM, ARE BEING MET.

Comply By: 01/03/25

4-200 Equipment Design and Construction

4-202.16

MN Rule 4626.0540 Provide non-food contact surfaces that are free of unnecessary ledges, projections and crevices and are designed and constructed to allow easy cleaning.

THE EPOXY COATING HAS CHIPPED OFF IN MULTIPLE AREAS ON THE WIRE RACKS IN THE UPRIGHT COOLER AND THE WIRE RACKS ARE RUSTING WHERE THERE IS NO COATING. DISCUSSED WITH STAFF REPLACING THESE RACKS.

Comply By: 02/18/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

STAFF DON'T HAVE A SINK STRAINER OR STOPPER THAT FIT INTO THE END SINK OF THE 3 COMP SINK SYSTEM, SO THEY WOULDN'T BE ABLE TO FILL ALL SINKS. DISCUSSED WITH STAFF GETTING A STOPPER THAT FITS THIS SINK SO IN CASE STAFF NEED TO THEY CAN FILL ALL 3 SINKS.

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Comply By: 01/18/25

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

THE HOT WATER HEATER WASN'T WORKING AT THE TIME OF THE INSPECTION. A PLUMBER HAS ORDERED PARTS FOR IT AND IT SHOULD BE REPAIRED BY 12/18.

Comply By: 12/19/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER DISPENSER
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Chlorine: = >200PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Chlorine: = 200 PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE-DILUTED
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: SLICED HAM
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: TURKEY BARLEY SOUP
Violation Issued: No

Process/Item: Undercounter Cooler
Temperature: 37 Degrees Fahrenheit - Location: CHEESE
Violation Issued: No

Process/Item: Beverage Dispenser
Temperature: 37 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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Process/Item: Cooking
Temperature: 189 Degrees Fahrenheit - Location: GRAVY
Violation Issued: No

Process/Item: Re-Heating
Temperature: 181 Degrees Fahrenheit - Location: CORN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: PIZZA
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: APPLE CIDER
Violation Issued: No

Process/Item: Re-Heating
Temperature: 190 Degrees Fahrenheit - Location: TURKEY
Violation Issued: No

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

COMMENTS:

INSPECTION ACCOMPANIED BY KITCHEN MANAGER, MICHAEL MEYER.

KITCHEN IS CLEAN AND ORDERLY.

THERE WAS NO HOT WATER AT THE TIME OF INSPECTION. THE PLUMBER IS WAITING ON A PART FOR THE HOT WATER HEATER AND STAFF STATED THAT IT SHOULD BE IN TOMORROW, 12/18. PUT SOME EMERGENCY PRECAUTIONS IN PLACE DURING THE INSPECTION AND DISCUSSED WITH STAFF MAKING FOOD SERVICE AS SIMPLE AS POSSIBLE UNTIL THERE IS HOT WATER.

COOK WAS HEATING WATER OF THE STOVE TOP UPON ARRIVAL FOR THE INSPECTION. A COFFEE URN WAS LOCATED DURING INSPECTION TO BE USED TO HOLD HEATED WATER FOR GRAVITY FED HAND WASHING. A BOTTLE OF HAND SANITIZER WAS ALSO BROUGHT IN FOR A SECONDARY STEP.

THE DISH WASHER WASN'T ABLE TO REACH 160F, SINCE IT WAS STARTING WITH COLD WATER AND THE BOOSTER ALONE COULDN'T MAKE IT. THE DISH WASHER CAN BE USED TO DO AN INITIAL WASH OF THE DISHES, BUT ONE OF THE COMPARTMENTS IN THE 3 COMP SINK WAS SET-UP WITH QUAT SANITIZER WATER- SO WASH DISHES IN DISH MACHINE, THEN DO A MANUAL SANITIZE OF THE DISHES IN THE SINK, THEN ALLOW TO AIR DRY.

WILL VERIFY WITH NURSING EVALUATOR, SATIVA BUSHEY, THAT HOT WATER IS

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REPAIRED ON 12/18. IF IT IS NOT REPAIRED BY THE 18TH A FOLLOW-UP WILL BE DONE TO CHECK HOT WATER.

STAFF STATED THEY ONLY USE THE BLEACH WATER FOR DINING ROOM TABLES. THE SPRAY BOTTLE WAS OVER 200 PPM WHEN TESTED. SPRAY BOTTLE WAS DILUTED TO 200 PPM. DISCUSSED MAINTAINING BLEACH WATER AT 50-200 PPM IN CASE IT IS USED ON A FOOD CONTACT SURFACE.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY SUSPECTED FOODBORNE ILLNESS COMPLAINTS.

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 1006241182 of 12/17/24.

Certified Food Protection Manager: Michael Meyer

Certification Number: FM26302 Expires: 02/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Michael Meyer
Kitchen Manager

Signed: _____

Callie Harrison

218-302-6173

callie.harrison@state.mn.us

Report #: 1006241182

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, & Lodging Services

P.O. Box 64975

Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out

0

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

12/17/24

Time In

10:00:00

Time Out

New Journey Residence

Address

100 Vermilion Trail

City/State

Biwabik, MN

Zip Code

55708

Telephone

2188654588

License/Permit #

0038664

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 complianceOUT= not in complianceN/O= not observedN/A= not applicableCOS=corrected on-site during inspectionR= 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 proceeedures 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 complianceMark "X" in appropriate box for COS and/or RCOS=corrected on-site during inspectionR= 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 labeled; 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

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

X

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)

Date:

12/18/24

Inspector (Signature)