Electronically Delivered

December 6, 2024

Licensee
Just Like Home Senior Care
29288 Old Towne Road
Chisago City, MN 55013

RE: Project Number(s) SL28155016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 5, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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 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: SL28155016 On November 4, 2024, through November 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four resident(s); all receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year 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	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of five residents and had a current census of four residents. On November 4, 2024, at 10:30 a.m., during the entrance conference, owner/licensed assisted living director (O/LALD)-A stated we still need to do this, we just took over in June and need to get this done. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated June 21, 2024, indicated a clinical nurse supervisor, or designee, will develop, write, and implement a staffing plan. The staffing plan will be evaluated for the appropriately of staffing levels in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	0 480		

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0 480	Continued From page 3 chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes	0 580		

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0 580	Continued From page 4 in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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 the residents). The findings include: On November 4, 2024, at 10:30 a.m., owner (O)-B stated they have discussed a lot of quality management topics from taking over, but nothing formal, and nothing documented. The licensee's Quality Management Plan policy dated June 21, 2024, indicated the Assisted Living Director will develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with current professional standards and the highest quality	0 580		

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0 580	Continued From page 5 services for residents. All staff will be involved in the implementation of performance improvement efforts. Documentation of quality management activity must be available for two years. Information must be available to the commissioner at the time of the survey, investigation, or renewal. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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 interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed or included a review/assessment of the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for three of four	0 630		

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0 630	Continued From page 6 residents (R1, R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's IAPP dated October 29, 2024, lacked an assessment of R1's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse. R3's IAPP dated October 1, 2024, lacked an assessment of R3's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse. R5's IAPP dated October 29, 2024, lacked an assessment of R5's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse. On November 5, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-C stated she would usually assess the residents to meet the IAPP requirements and was not sure why they were missed. The licensee's Individual Abuse Prevention Plans policy dated June 21, 2024, indicated the individual abuse prevention plan will include:	0 630		

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0 630	Continued From page 7 -individual review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults -the resident's risk of abusing other vulnerable adults -specific measures to minimize the risk of abuse to that person and other vulnerable adults -measure to minimize risk of self-abuse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the	0 660		

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0 660	Continued From page 8 most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a facility TB risk assessment, a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of two employees (clinical nurse supervisor (CNS)-C and unlicensed personnel (ULP)-E), a completed health history and symptom screening for one of two employees (CNS-C), and TB training for two of two employees (CNS-C and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility TB risk assessment was completed November 4, 2024, and indicated the facility was at a low risk for TB transmission. CNS-C CNS-C had a hire date of June 21, 2024, to provide supervision and oversight to unlicensed personnel and provide direct services to residents. CNS-C's employee record lacked a TB history and symptom screen, a two-step TST or other evidence of TB screening such as a blood test, and TB training. ULP-E ULP-E was hired July 9, 2024, and provided direct care services to licensee residents. ULP-E's record lacked the second step of a two-step TST or other evidence of TB screening	0 660		

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0 660	Continued From page 9 such as a blood test and TB training. On November 5, 2024, owner/licensed assisted living director (O/LALD)-A stated the new hires did not get screened or tested as required, they have been completing just one step and that would be the same for all new hires. O/LALD further stated the TB training had been assigned to the staff in Educare (online education system), but CNS-C and ULP-E have not yet completed the courses. O/LALD stated the TB facility risk assessment was likely done by the previous owner, but they have not yet updated one until today. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's TB Prevention and Control policy dated June 21, 2024, indicated the facility will establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention and information from the Minnesota Department of Health guidelines. Annually a community TB risk assessment will be	0 660		

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0 660	Continued From page 10 completed. Upon hire staff will be screened for TB symptoms and tested for TB. Staff are educated on basic infection control including bloodborne pathogens upon hire and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 4, 2024, at 12:50 p.m., owner (O)-B stated they have not yet fully developed the emergency preparedness plan. They bought the plan with the facility and were told it was complete but had not yet checked for themselves and was not aware it was not fully developed. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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.	01060		

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01060	Continued From page 12 (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: Based on interview and record review, the	01060		

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	28155	A. BUILDING: _____ B. WING _____	11/05/2024

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01060	Continued From page 13 licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 started receiving services on July 9, 2024. R1's record indicated R1 was hospitalized from July 16, 2024, until July 18, 2024, and again from August 25, 2024, until September 9, 2024. R1's record lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider - contact information for the Office of Ombudsman for Long-Term Care - 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 - 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 14 R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On November 5, 2024, at 11:00 a.m., owner/licensed assisted living director (O/LALD)-A stated they were not aware of the emergency relocation notification requirements and had not been doing this for any of the residents. The licensee's undated emergency relocation statement indicated 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 will provide contact information for the agency to which the resident may submit an appeal. (6) The notice required will be delivered as soon as practicable to: a) the resident, legal representative, and designated representative b) for residents who receive home and community-based waiver services under the	01060		

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01060	Continued From page 15 resident's case manager; and c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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;	01370		

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01370	Continued From page 16 (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: Based on interview and record review, the licensee failed to ensure required training was completed for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-E began employment on July 9, 2024, to provide direct care services. ULP-E's employee record lacked documentation of the following training and competency evaluations to be completed by ULP: -documentation requirements for all services provided -reports of changes in the resident's condition to	01370		

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01370	Continued From page 17 the supervisor designated by the assisted living director -basic infection control, including blood-borne pathogens -maintenance of a clean and safe environment -care and use of hearing aids -training on the prevention of falls for providers working with the elderly or individuals at risk of falls -standby assistance techniques and how to perform them -medication, exercise, and treatment reminders -basic nutrition, meal preparation, food safety, and assistance with eating -preparation of modified diets as ordered by a licensed health professional -awareness of confidentiality and privacy -procedures to utilize in handling carious emergency situations -awareness of commonly used health technology equipment and assistive devices On November 5, 2024, at 1:00 p.m., owner/licensed assisted living director (O/LALD)-A stated the training classes were assigned in Educare (online training platform) but they were not completed. O/LALD further stated they are working on streamlining the training process, so nothing gets missed. The licensee's Training Documentation policy dated June 21, 2024, indicated staff training will be documented completely and correctly. . No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 18	01380		
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 required training was completed for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01380		

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01380	Continued From page 19 ULP-E began employment on July 9, 2024, to provide direct care services. ULP-E's employee record lacked documentation of the following training and competency evaluations to be completed by ULP: -observation, reporting, and documenting of 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 resident -safe transfer and ambulation -range of motion and positioning On November 5, 2024, at 1:00 p.m., owner/licensed assisted living director (O/LALD)-A stated the training classes were assigned in Educare (online training platform) but they were not completed. O/LALD further stated they are working on streamlining the training process, so nothing gets missed. The licensee's Training Documentation policy dated June 21, 2024, indicated staff training will be documented completely and correctly. . No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 20 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) 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 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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	01470		

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01470	Continued From page 21 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) 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 interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for two of two employees (clinical nurse supervisor (CNS)-C and unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: CNS-C began employment on June 21, 2024, to provide oversight and supervision to unlicensed personnel and to provide direct services to residents.	01470		

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01470	Continued From page 22 CNS-C's employee record lacked the following required orientation content: -principles of person-centered planning and service delivery ULP-E began employment on July 9, 2024, to provide direct care services. ULP-E's employee record lacked the following required orientation content: -assisted living bill of rights -consumer advocacy services -principles of person-centered planning and service delivery On November 5, 2024, at 1:00 p.m., owner/licensed assisted living director (O/LALD)-A stated the training classes were assigned in Educare (online training platform) but they were not completed. O/LALD further stated they are working on streamlining the training process, so nothing gets missed. The licensee's Assisted Living & Assisted Living with Memory Care Orientation- All Staff policy dated June 21, 2024, indicated newly hired staff will receive orientation and training on topics required for assisted living organizations. . No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an	01490		

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01490	Continued From page 23 understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training in the required areas for two of two employees (clinical nurse supervisor (CNS)-C and unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: CNS-C began employment on June 21, 2024, to provide oversight and supervision to unlicensed personnel and to provide direct services to residents. ULP-E began employment on July 9, 2024, to provide direct care services. CNS-C and ULP-E's employee records lacked evidence of completing dementia care training in the following topics: - an explanation of Alzheimer's disease and other dementia's - assistance with activities of daily living - problem solving with challenging behaviors - communication skills and - person-centered planning and service delivery.	01490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: _____ B. WING _____	11/05/2024

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01490	Continued From page 24 On November 5, 2024, at 1:00 p.m., owner/licensed assisted living director (O/LALD)-A stated the dementia training classes were assigned in Educare (online training platform) but they were not completed. O/LALD further stated they are working on streamlining the training process, so nothing gets missed. The licensee's Assisted Living Dementia Training policy dated June 21, 2024, indicated dementia care training will include: An explanation of Alzheimer's Disease and other dementias Assistance with activities of daily living Problem solving with challenging behaviors Communication skills Person centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01530	Continued From page 25 initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 120 hours worked for one of one employee (clinical nurse supervisor (CNS)-C and 160 hours worked for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: CNS-C began employment on June 21, 2024, to provide oversight and supervision to unlicensed personnel and to provide direct services to residents.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01530	Continued From page 26 ULP-E began employment on July 9, 2024, to provide direct care services. CNS-C and ULP-E's orientation and training records lacked documentation of any of the required number of hours of dementia care training. On November 5, 2024, at 1:00 p.m., owner/licensed assisted living director (O/LALD)-A stated the dementia training classes were assigned in Educare (online training platform) but they were not completed. O/LALD further stated they are working on streamlining the training process, so nothing gets missed. The licensee's Assisted Living Dementia Training policy dated June 21, 2024, indicated supervisors of direct care staff will complete a minimum of 8 hours initial training on dementia care topics, initial training will be completed within 120 working hours of the employment start date. Direst-care staff will complete a minimum of 8 hours of initial training on dementia care topics, initial training will be completed within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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
01650	Continued From page 27 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident service plans included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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
01650	Continued From page 28 a large portion or all the residents). The findings include: R1 was admitted and began receiving services on July 9, 2024. R1's service plan dated July 12, 2024, lacked the following: -the methods of monitoring assessments of the resident -the schedule and methods of monitoring staff providing services -a contingency plan that includes: the action to be taken if the scheduled service cannot be provided -information and a method to contact the facility -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant change in the resident's condition, including identification of and information as to who has the authority to sign for the resident in an emergency and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters On November 5, 2024, owner/licensed assisted living director (O/LALD)-A stated they thought all the service plan requirements had been covered in the contract but will make the changes right away. The licensee's Contents of Service Plans policy dated June 21, 2024, indicated service plans will include the above missing content. No further information was provided.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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
01650	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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
01940	Continued From page 30 Based on observation, interview, and record review, the licensee failed to include a written statement of a treatment service on the resident's service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted on July 9, 2024. R1's Treatment Plan dated July 12, 2024, indicated R1 received blood sugar checks three times a day. On November 5, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-D check R1's blood glucose. R1's Service Plan dated July 12, 2024, lacked identification of treatment services related to R1's blood glucose monitoring. On November 5, 2024, owner/licensed assisted living director (O/LALD)-A stated the blood sugar monitoring for R1 should have been marked and included on the service plan. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated June 21, 2024, indicated the registered nurse will develop a medication, treatment, and/or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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
01940	Continued From page 31 therapy management plan as appropriate based upon the resident assessment and the services provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		

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

Type: Follow-Up
Date: *11/06/24*
Time: 12:00:00
Report: 1025241220

Food and Beverage Establishment Inspection Report

Location:
Just Like Home Senior Care
29288 Old Town Road
Chisago City, MN55013
Chisago County, 13

Establishment Info:
ID #: 0038906
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637420373
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 previously issued on 10/16/23 have NOT been corrected.

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.
Provide a test kit to test sanitizing solutions (e.g. chlorine bleach strips to 50-100 PPM)
Issued on: 10/16/23 *Comply By: 10/18/23*

4-300 Equipment Numbers and Capacities
4-301.12C
MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.
Provide a 3 compartment sink, or substitute sink basins or alternate basins for warewashing until a proper dishwasher can be purchased (look for NSF 184 Residental label)
Issued on: 10/16/23 *Comply By: 10/16/23*

No NEW orders were issued during this inspection.

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

CFPM copy received
Tracey L Rabiola
FM119498
09/18/2026
Post copy at est

Please see revision of 144G
(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;

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 1025241220 of 11/06/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

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

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

Type: Full
Date: *11/05/24*
Time: 12:00:00
Report: 1025241218

Food and Beverage Establishment Inspection Report

Location:
Just Like Home Senior Care
29288 Old Town Road
Chisago City, MN55013
Chisago County, 13

Establishment Info:
ID #: 0038906
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7637420373
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 previously issued on 10/16/23 have NOT been corrected.

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.

Provide a test kit to test sanitizing solutions (e.g. chlorine bleach strips to 50-100 PPM)

Issued on: 10/16/23 *Comply By: 10/18/23*

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Employ a CFPM for the establishment (search "MDH CFPM" for information)

Issued on: 10/16/23 *Comply By: 10/16/23*

4-300 Equipment Numbers and Capacities

4-301.12C

MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.

Provide a 3 compartment sink, or substitute sink basins or alternate basins for warewashing until a proper dishwasher can be purchased (look for NSF 184 Residental label)

Issued on: 10/16/23 *Comply By: 10/16/23*

Type: Full
Date: *11/05/24*
Time: 12:00:00
Report: 1025241218
Just Like Home Senior Care

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

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

***Orders on report reissued from previous inspection, unable to be cleared

Second kitchen freezer is ~30 deg F, so still frozen, but still food might be likely to thaw during a power outage, etc. Recommend adjusting colder.

Deli meat 41 deg F main refrigerator

Dishwasher does not meet standards for sanitizing. Provide a large basin on-site for chemical sanitizing until a dishwasher that meets the NSF 187 standard can be provided. Discussed standard and website and test kits for quat ammonia tablets during inspection.

Employ one CFPM per two licensed locations (within approved radius, MN 144G)
Recommend one central facility CFPM dedicated to the larger kitchen, and the other CFPM could be between two smaller locations if they are within the correct distance. Keep a copy of the CFPM on site, and if it's a photocopy, write down the address of the shared facility.

Discussed new facility built in North Branch. Food may be prepared in a central location and transported to other locations owned by the same company. Central kitchen would take temperatures of cold and hot TCS foods, and then receiving locations would also take temperatures upon receipt to ensure food remained at a safe and insulated temperature during transport. Large dishes and utensils returned would need to be W/R/S at main kitchen prior to re-use (so smaller facilities can clean the dishes before they're returned, but they still need to be sanitized again when received).

Frozen waffles from Walmart in freezer, recent recall for Listeria affected frozen waffles. If products were recalled, discard.
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota
https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/treehouse-foods-announces-expansion-voluntary-recall-include-all-waffle-and-pancake-products-due?permalink=8714173A91322D52CD40E167466B41AAA199FC885CD269AF91B957C4BB239D9B

Type: Full
Date: *11/05/24*
Time: 12:00:00
Report: 1025241218
Just Like Home Senior Care

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025241218 of 11/05/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

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