Electronically Delivered

February 11, 2025

Licensee
Home Joy Home Care Inc
1908 Laramie Trail
Brooklyn Park, MN 55444

RE: Project Number(s) SL40330015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on January 15, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40330	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME JOY HOME CARE INC	1908 LARAMIE TRAIL BROOKLYN PARK, MN 55444

(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: SL40330015-0 On January 13, 2025, through January 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were zero (0) residents; zero receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (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 ensure a staffing plan was developed, potentially affecting all the licensee's past and 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, but was not likely to cause serious injury, impairment, or death), and	0 470		

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0 470	Continued From page 2 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 January 13, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-A stated the licensee currently did not have any residents and explained when R1 was admitted for services, the licensee determined the staffing requirements based on assessment and created a staff schedule. CNS-A stated the licensee did not develop a written staffing plan as required. During interview on January 13, 2025, at approximately 12:20 p.m., CNS-A stated R1 was admitted for services on April 18, 2024, and required one on one supervision twenty-four hours a day, seven days a week. On May 18, 2024, R1 was admitted to the hospital and did not return to licensee. CNS-A stated they have not had any residents since then. CNS-A was not aware of the requirement to have a written staffing plan. The licensee's Admission policy revised 2023, indicated residents were accepted into the program if the facility had staff sufficient in qualifications, competency, and numbers to provide services agreed to in the assisted living contract. The policy also indicated there must be adequacy and suitability of facility personnel and resources to provide the services required by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 470		

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0 470	Continued From page 3 (21) days	0 470		
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 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	0 480		

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0 480	Continued From page 4 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: 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 January 14, 2025, for the specific	0 480		

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0 480	Continued From page 5 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		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two	0 650		

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0 650	Continued From page 6 employees (unlicensed personnel (ULP)-B, 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, 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 January 13, 2025, at 11:15 a.m., owner/licensed assisted living director (O/LALD)-C and clinical nurse supervisor (CNS)-A provided an undated employee roster which indicated ULP-B and ULP-E's date of hire was April 2024. On January 13, 2025, at 1:08 p.m., O/LALD-C stated both ULP-B and ULP-E were hired on April 1, 2024, to provide assisted living services. ULP-B and ULP-E's [Licensee] Assisted Living Staff Orientation Outline & Sign-Off signed by each ULP and CNS-A on April 25, 2024, and April 16, 2024, respectively, lacked documentation of training methodology (such as classroom style, web-based training, video, or one-to-one training). On January 14, 2025, at 11:05 a.m., CNS-A stated the orientation checklist was used for training documentation, but she did not go over every single item on the checklist but did "most of it." CNS-A stated they understood how it would be difficult to know what topics were covered because they were not marked indicating they	0 650		

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0 650	Continued From page 7 were covered. During phone interview on January 15, 2025, at 11:01 a.m., ULP-B explained she was hired to work at this facility (licensee's owner has another facility) but did not start providing services to R1 until "later" (could not give a specific amount of time). ULP-B stated she received training by the nurse and did one-to-one training which included resident bill of rights, assisted living statutes, provider's policies and procedures, medication administration, tuberculosis, infection control, and dementia training (could not specify the number of hours), and other topics. ULP-B also stated the nurse observed her perform medication administration. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subpart 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and	0 650		

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0 650	Continued From page 8 (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. The licensee's Employee Records policy revised 2023, indicted the employee record would include records of orientation, required annual training, infection control training and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 9 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. The licensee also failed to post emergency exit diagrams on each floor. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 13, 2025, at 12:00 p.m., during facility tour with clinical nurse supervisor (CNS)-A, the surveyor noted a split style home. Upon entry of the home, there was an entry way with closet and a bulletin board on the wall between the front door and the garage entry door. There were steps to go upstairs or downstairs. The upper level had three unoccupied bedrooms, and the lower level had one unoccupied bedroom. The surveyor observed the upper-level emergency exit diagram posted on the bulletin board entry way wall. The	0 680		

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0 680	Continued From page 10 surveyor did not observe an emergency exit diagram posted on the upper level nor the lower level. On January 13, 2025, at 1:00 p.m., owner/licensed assisted living director (O/LALD)-C stated there were no emergency exit diagrams posted on either floor, just the one in the entry way. O/LALD-C stated he would print and post the diagrams. The licensee's emergency disaster preparedness plan created August 20, 2022, lacked evidence of the following required content: -documentation of the date of review and any updates made to the plan based on the review; -documentation of the date of review and any updates made to the EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; -maintain and annual EP updates: -categorize the various probable risks/hazards by likelihood of occurrence; -develop strategies for addressing facility and community-based risks (disruption of utilities, emerging infectious diseases (EIDs); -missing resident plan and documentation of quarterly review; -process for collaboration with local, tribal, regional, state and federal EP to maintain integrated response; - the development of policies/procedures to address: -subsistence needs for staff and residents specific to the needs of the facility; -alternate sources of energy to maintain temperatures to protect resident health/safety and sewage and waste disposal; -shelter in place; -use of volunteers;	0 680		

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0 680	Continued From page 11 -role of facility under a waiver declared by the secretary; and -emergency officials contact information. On January 15, 2025, at 3:02 p.m., the surveyor asked where to find shelter-in place information within the EPP, O/LALD-C explained the licensee would not use this facility to shelter other people. O/LALD-C explained for a power outage, the EPP indicated there were blankets available. For the missing resident plan, O/LALD-C stated it was not in the EPP. O/LALD-C stated the EPP was created in 2022, and they had reviewed it a couple of times but did not document the review. The licensee's Emergency Management Policy revised 2023, indicated the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service	0 730		

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	40330	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME JOY HOME CARE INC	1908 LARAMIE TRAIL BROOKLYN PARK, MN 55444

(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
0 730	Continued From page 12 providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 730		

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0 730	Continued From page 13 licensee failed to ensure documentation of the services being provided for one of one resident (R1) receiving weekly medication set up by the registered nurse (RN) and assistance with activities of daily living. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to licensee for services on April 18, 2024, and had diagnoses including personality disorder and major depression. R1's Service Plan Agreement signed April 22, 2024, indicated R1 received services including medication administration, behavior management, meals, housekeeping, laundry, and continuous one on one supervision. MEDICATION SET UP During entrance conference on January 13, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-A stated they set up medications weekly in medication boxes to be administered by the unlicensed personnel (ULPs). R1's medication administration record (MAR) dated May 1, 2024, through May 18, 2024, indicated R1 was given two medications for depression, ointment for a wound, medication for allergies, medication for hyperactivity disorder,	0 730		

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0 730	Continued From page 14 medication for indigestion, anti-psychotic medication, vitamins, medication for esophagus inflammation, three medications for insomnia, four medications for agitation/anxiety, medication for muscle spasms, and two medications for pain/migraines. The MAR also included documentation of medication administration using staff initials. R1's record lacked a medication setup record with the following required content: -dates of medication set up; -name of medication; -quantity of dose; -times to be administered; -route of administration; and -name of person completing medication setup. On January 14, 2025, at 10:35 a.m., when asked for documentation of medication set up, CNS-A stated she documented on a separate MAR that mirrored the MAR used for administration but was unable to locate the documentation. Through e-mail communication on January 20, 2025, at 2:30 p.m. (after the survey was completed), CNS-A informed the surveyor she located the medication set up documentation which was filed in a notebook stored at another facility owned by the same owner. SERVICE DOCUMENTATION R1's medical record lacked documentation that housekeeping and laundry were provided. R1's [Licensee] Progress Notes dated April 18, 2024, through May 18, 2024, included notes on behavior, some meals, activities made by CNS-A. On January 14, 2025, at 1:20 p.m., CNS-A stated	0 730		

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0 730	Continued From page 15 she did not have service documentation available to show but she stated she used a timecard for each staff person which listed different services one could provide during that shift. CNS-A stated the timecards were not part of R1's record. The licensee's Medication Set Up Policy revised 2023, indicated the facility staff setting up medications would follow accepted standards of practice and indicated a MAR or other medication documentation method should be used to set up medications. The policy did not specify the required content to be included in the documentation records. The licensee's Resident Records policy revised 2023, indicated the resident's record would include documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide egress windows in compliance with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents.	0 775		

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0 775	Continued From page 16 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: On January 15, 2025, from 12:30 p.m. to 1:05 p.m., the surveyor toured the facility with owner/licensed assisted living director (O/LALD)-C. The following was observed: The windowsill height in resident room 4 was 50 inches from the finished floor. The maximum height from the floor shall not exceed 48 inches. Per Minnesota State Fire Marshal Policy, escape windows with openings up to 52 inches off of the floor may meet the height requirement for existing buildings by securing a step, platform or bed to the wall directly underneath the window. This step, platform or bed shall be no more than 44 inches below the opening and must be strong enough to support the weight of the person. The minimum acceptable width shall be the same as the window opening. The minimum acceptable depth away from the wall shall be 18 inches. TIME PERIOD FOR CORRECTION: Two (2) day	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 17 (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 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff,	0 810		

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0 810	Continued From page 18 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). The findings include: On January 15, 2025, owner/licensed assisted living director (O/LALD)-C 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's FSEP, titled "Fire Plan", undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.	0 810		

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0 810	Continued From page 19 TRAINING: The licensee failed to provide evacuation training to residents at least once per year. O/LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers	0 940		

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0 940	Continued From page 20 provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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). The findings include: R1 was admitted to licensee for services on April 18, 2024, and had diagnoses including personality disorder and major depression. R1's Service Plan Agreement dated April 22, 2024, indicated R1 received services including medication administration, behavior management, housekeeping, laundry, and	0 940		

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0 940	Continued From page 21 continuous one on one supervision. R1's [Licensee] Resident Contract for Assisted Living signed April 22, 2024, lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; and - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b). On January 14, 2025, at 10:05 a.m., owner/licensed assisted living director (O/LALD)-C stated R1's contract was the current contract in use for all residents. O/LALD-C was unaware the missing information was required and stated the information in the contract could be confusing. The licensee's Assisted Living Contracts policy revised in 2023, indicated the contract must include a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; and - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b). No further information was provided.	0 940		

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0 940	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident (R1). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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 was admitted to licensee for services on April 18, 2024, and had diagnoses including personality disorder and major depression.	0 970		

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0 970	Continued From page 23 R1's [Licensee] Resident Contract for Assisted Living signed April 22, 2024, included the following clause which indicated the resident would waive the licensee's liability for injury to resident or personal property of the resident: -On page 10 of the contract, section "24. PROVISIONS RELATED TO LIABILITY A. Damage of Injury to Resident of Resident's Property. We are not responsible for any damage or injury suffered by you, your property... that was not caused by us." On January 14, 2025, at 10:05 a.m., owner/licensed assisted living director (O/LALD)-C stated R1's contract was the current contract in use for all residents. After contract review at 10:21 a.m., O/LALD-C stated the licensee could not be responsible for items of high value, but stated they would update the contract to remove the waiver of liability. O/LALD-C also stated they received the contract from a consultant, so he assumed it was sufficient. The licensee's Assisted Living Contracts policy revised in 2023, indicated the contract must not include a waiver of facility liability for the health and safety or personal property of a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
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	01060		

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01060	Continued From page 24 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; (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	01060		

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01060	Continued From page 25 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 a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative 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 was admitted to licensee for services on April 18, 2024, and had diagnoses including personality disorder and major depression. R1's Service Plan Agreement signed April 22, 2024, indicated R1 received services including medication administration, behavior management, meals, housekeeping, laundry, and continuous one on one supervision. R1's [Licensee] Progress Notes dated May 18, 2024, at 2:19 p.m., indicated R1 was sent to hospital from a primary clinic appointment. The progress note also indicated R1 was not coming back per clinical nurse supervisor (CNS)-A. R1's record lacked documentation R1, R1's legal representative, and R1's designated representative received a written notice with all	01060		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 26 the required content for an emergency relocation. On January 14, 2025, at 2:09 p.m., CNS-A stated she did not use the emergency relocation notification form but had read about it and was somewhat familiar with the requirement. CNS-A stated she did not complete the written notice and was not aware she needed to notify the Office of Ombudsman for Long-Term Care (OOLTC) if the resident has been relocated and has not returned to the facility within four days. The licensee's Assisted Living Contract Terminations policy revised 2023, indicated the licensee would as soon as possible provide written notice of emergency relocation to the resident, the resident's legal representative, the resident's designated representative, and the resident's case manager if they received home and community-based services. The policy also indicated the licensee would notify the OOLTC if the resident has been relocated and has not returned to the facility within four days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40330	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME JOY HOME CARE INC	1908 LARAMIE TRAIL BROOKLYN PARK, MN 55444

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01530	Continued From page 27 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 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 interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on required topics within 160 working hours of the employment start date for two of two direct care employees (unlicensed personnel (ULP)-B, 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:	01530		

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01530	Continued From page 28 During entrance conference on January 13, 2025, at 11:15 a.m., owner/licensed assisted living director (O/LALD)-C and clinical nurse supervisor (CNS)-A provided an undated employee roster which indicated ULP-B and ULP-E's date of hire was April 2024. CNS-A explained they had one resident at the time of hire which they staffed one person per 12-hour shift. At 1:08 p.m., O/LALD-C stated both ULP-B and ULP-E were hired on April 1, 2024, to provide assisted living services. ULP-B ULP-B's Inservice/Education dated April 2024, indicated "Dementia" on April 29, 2024, lacked topics covered or hours completed. ULP-B's [Licensee] Assisted Living Staff Orientation Outline & Sign-Off signed by ULP-B and CNS-A on April 25, 2024, indicated "Dementia and Related Diseases" on May 8, 2024, which lacked the number of hours or topics covered. ULP-B's employee record lacked further dementia care training. ULP-E ULP-E's Inservice/Education form indicated "Dementia" on April 16, 2024, lacked topics covered or hours completed. ULP-E's [Licensee] Assisted Living Staff Orientation Outline & Sign-Off signed by ULP-B and CNS-A on April 16, 2024, indicated "Dementia and Related Diseases," which lacked the number of hours or topics covered.	01530		

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01530	Continued From page 29 On January 13, 2025, at 1:30 p.m., CNS-A stated she provided dementia care training using one-to-one training method and documented the training using the "Assisted Living Staff Orientation Outline & Sign-Off" form and "Inservice/Education" form. After the training, CNS-A stated she went over the dementia quizzes with the staff. The surveyor asked how many hours of dementia training was provided and what topics were covered, CNS-A provided the surveyor the objectives for two dementia courses she covered and stated between both courses it was 5 hours total. CNS-A was not aware eight (8) hours of dementia training was required, she thought it was three (3) hours total. During phone interview on January 15, 2025, at 11:01 a.m., ULP-B explained she was hired to work at this facility (licensee's owner has another facility) but did not start providing services to R1 until later (could not give a specific amount of time). ULP-B stated she received training by the nurse and did one-to-one training which included resident bill of rights, assisted living statutes, provider's policies and procedures, medication administration, tuberculosis, infection control, and dementia training (could not specify the number of hours completed). The licensee's Dementia Care Training policy revised 2023, indicated direct care employees would complete eight hours of initial dementia training on required topics in the 160 hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 30	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool per Minnesota Rule 4659.0150 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	01620		

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01620	Continued From page 31 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 the entrance conference on January 13, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-A stated assessments were completed upon admission, within 14-days, quarterly, and with a change in condition. R1 was admitted to licensee for services on April 18, 2024, and had diagnoses including personality disorder and major depression. R1's Service Plan Agreement signed April 22, 2024, indicated R1 received services including medication administration, behavior management, meals, housekeeping, laundry, and continuous one-to-one supervision. R1's Comprehensive Physical Assessment and Skilled Care Note (initial RN assessment) dated April 20, 2024, lacked the following requirements of the uniform assessment tool: -personal lifestyle preferences- sleep schedule, social needs, spiritual and cultural preferences; -instrumental activities of daily living-housework/laundry and transportation; -infectious conditions; -nutritional and hydration status and preferences; -risk factors (risk for falling including history of falls was addressed); -who has decision-making authority for the resident; and	01620		

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01620	Continued From page 32 -the need for follow-up referrals for additional medical or cognitive care by health professionals. R1's Review of Systems/Physical Assessment 14 Day (14-day RN assessment) dated May 1, 2024, lacked the following requirements of the uniform assessment tool: - personal lifestyle preferences- sleep schedule, social needs, spiritual and cultural preferences; -allergies and sensitivities related to medication, seasonality, environment, and food and if any are life threatening; -infectious conditions; -pain-intensity and effectiveness of medication and nonmedication alternatives; -nutritional and hydration status and preferences; -risk factors (history of falls was addressed); and -the need for follow-up referrals for additional medical or cognitive care by health professionals. On January 15, 2025, at 1:17 p.m., during R1's assessment review, CNS-A explained for the 30-day and 90-day review, she used the following forms: Comprehensive Physical Assessment, and the 30-day assessment form. She also explained she would refer to the previous assessment to note any changes based on current observations. CNS-A was not aware of the nutritional and hydration status preferences but indicated any modified diets when necessary. On January 15, 2025, at 2:42 p.m., when discussing the requirements of the uniform assessment tool, CNS-A stated she was told by another surveyor during survey at another facility that she needed to use the comprehensive assessment which she did. The comprehensive assessment did not include all the required content and CNS-A was not aware it was still missing content.	01620		

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01620	Continued From page 33 The licensee's Nursing Assessment and Reassessment of Residents policy revised 2023, indicated a comprehensive assessment would be conducted by the RN pre-admission, completed within 14 days after start of services, with change of condition and at least every 90 days. The policy also indicated the assessment would include the requirements outlined in MN Rules. Minnesota Administrative Rules Chapter 4659.0140, Subpart 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 34 (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 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 the resident service plan included 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	01650		

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01650	Continued From page 35 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's service plan signed April 22, 2024, indicated R1 received services which included assistance with medication management, activities, behavior management, meals, shopping, 24-hour one-on-one supervision, scheduling appointments, transportation, laundry, and housekeeping. R1's service plan lacked the following: - the identification of staff or categories of staff who will provide the services; and - the schedule and methods of monitoring staff providing services. On January 14, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated she was not aware of the required service plan content. The licensee's Service Plan policy revised 2023, indicated the service plan would include identification of staff or categories of staff who would provide the services, and the schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/14/25*
Time: 11:16:27
Report: 1021251008

Food and Beverage Establishment Inspection Report

Location:
Home Joy Care Of Laramie Trail
1908 Laramie Trail
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0038130
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633605991
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

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE. A THERMOLABEL WAS LEFT ON-SITE. SEE COMMNETS.

Comply By: 01/21/25

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.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 01/21/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

THE EXTERIOR OF THE KITCHEN REFRIGERATOR HAS DRIED LIQUID SPLATTERS. CLEAN AND SANITIZE THE REFRIGERATOR.

Comply By: 01/16/25

Food and Equipment Temperatures

Type: Full
Date: *01/14/25*
Time: 11:16:27
Report: 1021251008
Home Joy Care Of Laramie Trail

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

All FINDINGS ON THIS REPORT WERE DISCUSSED WITH DIRECTOR, JEAN MOUELLE AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ANNA BOHNEN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 0 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH STAFF, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL, VINYL FLOORS AND LAMINATE COUNTERTOPS. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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 1021251008 of 01/14/25.

Certified Food Protection Manager: JEANEL K. MOUELLE

Certification Number: FM114138 Expires: 12/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
JEAN MOUELLE
DIRECTOR

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us