Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 24, 2025

Licensee
Journeys Home Care LLC
3264 Xenia Avenue North
Crystal, MN 55422

RE: License Number 419208
Health Facility Identification Number (HFID) 37615
Project Number(s) SL37615015

Dear Licensee:

On February 18, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed July 16, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective February 24, 2025.

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.

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 25, 2024

Licensee
Journeys Home Care LLC
3264 Xenia Avenue North
Crystal, MN 55422

RE: Conditional License Number 414651
Health Facility Identification Number (HFID) 37615
Project Number(s) SL37615015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on October 9, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **February 23, 2025**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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 . . ."

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $500.00. **MDH is not imposing these fines against your license at this time.**

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 16, 2024, found not corrected at the time of the October 9, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) - $500.00

The details of the violations noted at the time of this follow-up survey completed on October 9, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on

the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Journeys Home Care LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Journeys Home Care LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **Health Facility Construction Permit:** Journeys Home Care LLC will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. **Within 21- days from the date of this notice, Journeys Home Care LLC will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.**

b. **General Contractor:** Journeys Home Care LLC must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email **within 21-days of the date of this notice:**

    i. Name

    ii. License Number

iii. Contact Information

c. **Egress Window Requirements:** Journeys Home Care LLC will replace at least one window in unoccupied resident bedroom 1, unoccupied resident bedroom 2, and occupied resident bedroom 3, meeting the minimum size requirements.

i. Must have minimum openable width of no less than 20 inches.
ii. Must have minimum openable height of no less than 20 inches.
iii. Must have total openable area of no less than 648 square inches (4.5 square feet).
iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
v. All measurements much be achieved under normal operation of opening window without the use of a key, too. or special knowledge.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Journeys Home Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Journeys Home Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Journeys Home Care LLC's assisted living facility license, and Journeys Home Care LLC will correct any outstanding violations identified during the survey. If Journeys Home Care LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37615	A. BUILDING: _____ B. WING _____	R 10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	3264 XENIA AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37615015-1 On October 7, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on July 16, 2024. At the time of the survey, there were 3 active residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	{0 460}		

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{0 460}	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 460}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	{0 470}		

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{0 470}	Continued From page 2 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: Not reviewed during this survey.	{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, chapter 4626; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and	{0 550}		

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{0 550}	Continued From page 3 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 550}		
{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: Not reviewed during this survey.	{0 630}		

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{0 650}	Continued From page 4	{0 650}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 650}		
{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	{0 660}		

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{0 660}	Continued From page 5 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: Not reviewed during this survey.	{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	{0 680}		

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{0 680}	Continued From page 6 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: Not reviewed during this survey.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}		

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{0 780}	Continued From page 7 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee 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) Employees of assisted living facilities shall receive training on the fire safety and evacuation	{0 810}		

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{0 810}	Continued From page 8 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 employees 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: Not reviewed during this survey.	{0 810}		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	{0 820}		

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{0 820}	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied residents in bedrooms 1, 2, and 3 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 July 16, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom 3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 14.5 inches in height and 33 inches in width, with a total openable area of 478.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.	{0 820}		

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{0 820}	Continued From page 10 It was observed that unoccupied resident bedroom 2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 14.5 inches in height and 33 inches in width, with a total openable area of 478.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed unoccupied resident bedroom 1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 18 inches in height and 41inches in width, with a total openable area of 738 square inches. The windows did not meet the minimum requirements for opening height. On July 16, 2024, at 11:00 a.m., during the interview, survey staff explained to LALD/CNS-A that an immediate correction order was issued for the above finding. LALD/CNS-A acknowledged the above finding. On October 7, 2024, at 10:00 a.m. during an interview, licensed assisted living director (LALD)-A stated they had not replaced the windows to meet the minimum egress, due to the contractor not being able to make the time. LALD-A stated they had purchased the windows and are just waiting for a time from the contractor. LALD-A stated licensee continued to complete the fire watch for the safety of the residents. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no	{0 820}		

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	37615	A. BUILDING: _____ B. WING _____	R 10/09/2024

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{0 820}	Continued From page 11 less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD/CNS-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD/CNS-A verbally confirmed the findings. No Further information was provided.	{0 820}		
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative	{0 900}		

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{0 900}	Continued From page 12 according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 900}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	{01440}		

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{01440}	Continued From page 13 by: Not reviewed during this survey.	{01440}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	{01500}		

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{01500}	Continued From page 14 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01500}		
{01530} SS=E	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	{01530}		

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{01530}	Continued From page 15 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: Not reviewed during this survey.	{01530}		
{01610} SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods	{01610}		

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{01610}	Continued From page 16 based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01610}		
{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: Not reviewed during this survey.	{01620}		

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{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01640}		
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be	{01700}		

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{01700}	Continued From page 18 provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01700}		
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided;	{01730}		

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{01730}	Continued From page 19 (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01730}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	{01880}		

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{01880}	Continued From page 20 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}		
{02240} SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term	{02240}		

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{02240}	Continued From page 21 Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02240}		

Electronically Delivered

August 14, 2024

Licensee
Journeys Home Care LLC
3264 Xenia Avenue North
Crystal, MN 55422

RE: Project Number(s) SL37615015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

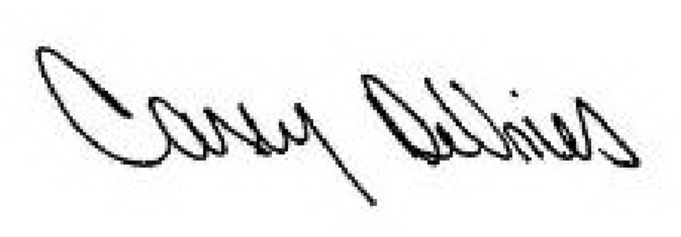
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

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JOURNEYS HOME CARE LLC	3264 XENIA AVENUE NORTH CRYSTAL, MN 55422

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37615015-0 On July 15, 2024, through July 16, 2024, the Minnesota Department of Health conducted an Assisted Living license survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident receiving services under the Assisted Living license. An immediate correction order was identified on July 16, 2024, issued for SL37615015-0, tag identification 0820. On July 16, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	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 Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

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	37615	A. BUILDING: _____ B. WING _____	07/16/2024

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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:	0 460		

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0 460	Continued From page 2 On July 15, 2024, at 9:42 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not provide a system for residents to summon staff 24/7 (24 hours a day 7 days per week). They stated if a residents needed assistance they would just need to yell for help. On July 15, 2024, at 10:17 a.m., during the facility tour with LALD/CNS-D, the surveyor observed the licensee lacked a summoning system for residents to use to summon staff for assistance. On July 16, 2024, at 10:36 a.m., R2 stated they were not offered a means to summons staff 24/7. R2 stated if they required assistance they would just call out for help. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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;	0 470		

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0 470	Continued From page 3 (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 in accordance with Minnesota Administrative Rule 4659.0180 Subpart 3., at at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of four	0 470		

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0 470	Continued From page 4 residents, and during the survey had a census of one resident. On July 15, 2024, at 9:42 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not have a staffing plan. LALD/CNS-A stated they just made sure staff were scheduled for all shifts. On July 16, 2024, at 12:12 p.m., LALD/CNS-A stated they were unable to locate a written staffing plan. The licensee's Staffing policy dated August 1, 2021, which indicated: "1. The staffing plan to determine the required staffing level is prepared by the clinical nurse supervisor. 2. The plan considers the number of qualified direct-care staff (home health aides) to meet the residents' needs throughout the day and night. 3. The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. Considerations include: -The staffing requirements to meet the scheduled and reasonably foreseeable unscheduled needs of the residents based on the assessment and service plan -The acuity level of the residents based on the nursing assessment -The facility's ability to respond promptly and effectively to residents -Staff experience, training and competence -Dementia care requirements -The physical layout of the residence 4. Residents are provided with a means to request assistance for health and safety needs 24 hours/day 7 days/week; during night shifts, the	0 470		

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0 470	Continued From page 5 home health aide will respond to resident requests for assistance as soon as possible. 5. A daily staffing schedule is prepared by the clinical nurse supervisor and addresses: -Home health aide work schedules for each home health aide showing all work shifts with days/hours worked -The home health aide's resident assignments or work location 6. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public. 7. At least two (2) home health aides will be scheduled and available for residents requiring the assistance of two home health aides for scheduled and reasonably foreseeable unscheduled needs as reflected in the assessment and service plan." 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, 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	0 480		

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0 480	Continued From page 6 Food Code. This had the potential to affect all residents of the assisted living facility. 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 included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 15, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on July 15, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also	0 550		

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0 550	Continued From page 7 state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information directing individuals to the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH) if they had complaints about the facility or person providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2024, at 10:17 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed the facility's, "Grievance/Complaint Procedure" posting on the end of the kitchen cupboard which lacked information directing individuals to the OHFC at the MDH. LALD/CNS-A stated they thought the information was posted with their grievance posting. The licensee's Grievance policy dated August 1, 2021, indicated: "Residents and their families or responsible parties may also complain to the Minnesota	0 550		

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0 550	Continued From page 8 Department of Health, Office of Health Facility Complaints at: a. 85 East Seventh Place, Suite 300 b. P.O. Box 64970 c. St. Paul, MN 55164-0970 d. (651) 201-4201" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) which contained required assessment content was completed on admission for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 630		

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0 630	Continued From page 9 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 admitted to the licensee on January 25, 2023. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation, and transportation. R2's record included an Abuse Prevention Plan dated March 1, 2021, completed while R2 was a resident at the licensee's sister facility prior to their admission to the current licensee. R2's record lacked an IAPP completed when they were admitted to the current licensee. On July 16, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R2. On July 15, 2024, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was a transferred resident from one of their sister facilities in 2022. The surveyor explained a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. LALD/CNS-A stated they were unaware	0 630		

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0 630	Continued From page 10 a resident could not be transferred between facilities under different licenses and a new IAPP should have been completed upon admission. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 650		

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0 650	Continued From page 11 review, the licensee failed to ensure employee records contained annual performance reviews for two of three employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired on February 25, 2022, to provide direct cares to residents. ULP-B's employee record lacked evidence the following items were completed: -annual performance reviews. ULP-C ULP-C was hired on July 2, 2021, to provide direct cares to residents. ULP-C's employee record lacked evidence the following items were completed: -annual performance reviews. On July 16, 2024, at 9:02 a.m., the surveyor observed ULP-B administer medication to R2. On July 16, 2024, at 8:38 a.m., LALD/CNS-A stated they had not been completing annual performance review for their employees. LALD/CNS-A stated they had just been forgetting	0 650		

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0 650	Continued From page 12 they needed to be completed. The licensee's Personnel Records policy dated August 1, 2021, indicated: "2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: -Evidence of current professional licensure, registration or certification -Results of background studies -Records of annual training and infection control training -Documentation of orientation -Documentation of supervision, as applicable -Performance reviews -Competency evaluations -Signed job description -Documentation of annual performance reviews identifying areas of improvement needed and training needs" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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,	0 660		

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0 660	Continued From page 13 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee TB test chest Xray's (CXR) were completed within 90 days of a documented positive Mantoux skin test or blood test for two of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-B). Further, the licensee failed to ensure annual TB training was completed for three of three employees (LALD/CNS-A, ULP-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's facility TB risk assessment dated December 25, 2023, indicated the facility was at a low risk level. LALD/CNS-A LALD/CNS-A was hired on February 17, 2019, to perform administrative duties, clinical duties, and to provide oversight to unlicensed personnel.	0 660		

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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
0 660	Continued From page 14 LALD/CNS-A's employee record included a Baseline TB Screening Tool for Healthcare Workers form dated February 20, 2022. It indicated LALD/CNS-A had a positive Mantoux skin test, 0.2 millimeters (mm), on April 6, 2000. LALD/CNS-A's employee record included a CXR imaging result dated November 28, 2012, which indicated the CXR was conducted due to unspecified chest pain. It did not indicate the CXR was done to check for active or latent TB. The CXR was not conducted within 90 days of the positive documented Mantoux skin test on April 6, 2000. LALD/CNS-A's employee record included an Educare (an online training platform) transcript which indicated LALD/CNS-A's most recent TB training was completed on March 16, 2022, in the OSHA and Infection Control -BELTSS training module. LALD/CNS-A's employee record lacked annual TB training required to be completed by March 16, 2023, and then again in 2024. ULP-B ULP-B was hired on February 25, 2022, to provide direct cares to residents. ULP-B's employee record included a CXR result dated November 8, 2022. It indicated, "History: TB SCREENING". ULP-B's record lacked a positive TB test result completed via a Mantoux skin or blood test completed within 90 days of the CXR. ULP-B's employee record included an Educare transcript which indicated ULP-B's most recent TB training was completed on April 19, 2023, in the OSHA and Infection Control training module. ULP-B's employee record lacked annual TB	0 660		

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	37615	A. BUILDING: _____ B. WING _____	07/16/2024

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0 660	Continued From page 15 training required to be completed by April 19, 2024. ULP-C ULP-C was hired on July 2, 2021, to provide direct cares to residents. ULP-C's employee record included an Educare transcript which indicated ULP-C's most recent TB training was completed on September 11, 2022, in the OSHA and Infection Control training module. ULP-C's employee record lacked annual TB training required to be completed by September 11, 2023. On July 15-16, 2024, the surveyor observed LALD/CNS-A performing their duties throughout the survey. On July 16, 2024, at 9:02 a.m., the surveyor observed ULP-B administer medication to R2. On July 15, 2024, at 1:35 p.m., LALD/CNS-A stated they thought a TB CXR was good forever. The surveyor explained the CXR is only valid if completed within 90 days of a positive Mantoux skin or blood test. On July 16, 2024, at 8:38 a.m., LALD/CNS-A stated ULP-B had not completed annual TB training. LALD/CNS-A stated they used Educare for all of their employee annual training so if it wasn't completed in Educare then the employee did not complete the training. The CDC Tuberculosis Guidance website, last updated December 15, 2023, indicated all health personnel should receive baseline TB screening and testing upon hire. It further indicated all health care personnel should receive annual TB	0 660		

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0 660	Continued From page 16 education. The Minnesota Department of Health TB FAQ, last updated on April 3, 2024, indicated: -all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification; -TB testing should be dated within 90 days before hiring; -baseline TB screening is required at the time of hire for all health care personnel in Minnesota; and -if the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated, "On-going education regarding TB will be provided annually as part of the infection control training." It also indicated, "Baseline TB Testing: Baseline TB screening at the time of hire is required for all HCWs in Minnesota. Baseline TB screening consists of three components: (1) assessing for current symptoms of active TB disease, and (2) assessing TB history and 3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test." It further indicated: "8. Employees with written documentation of a previous positive TST or BAMT do not need a repeat TST or BAMT: -Assess for current TB symptoms -If they provide written documentation of the results of a chest x-ray indicating no active TB	0 660		

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0 660	Continued From page 17 disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. -If they do not have the written documentation from above, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease before having direct patient contact. -Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. -After the baseline chest x-ray is performed and the result is documented, repeat x-rays are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph." 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.	0 680		

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0 680	Continued From page 18 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors to view. 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 July 16, 2024, the licensee's Emergency Preparedness Plan last reviewed on November 11, 2023, was reviewed by the surveyor and lacked the following required information: -Evidence the licensee developed strategies for addressing facility & community-based risks (staffing surges/shortages, back-up plans); -Evidence of quarterly update for their missing	0 680		

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0 680	Continued From page 19 resident plan quarterly (was last reviewed on November 11, 2023); -Evidence of who would assume specific roles in another's absence through succession planning and delegation of authority; -Evidence of a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; -Evidence of evacuation transportation; -Evidence the licensee developed and implemented EP P/P to address the following whether evacuated or shelter in place for staff/residents: -Food, water, medical supplies, pharmaceutical supplies -Identify alternate sources of energy to maintain: -Temperatures to protect resident health/safety -Safe/sanitary storage of provisions -Emergency lighting -Fire detection, extinguishing, alarm systems -Sewage and waste disposal -Evidence the licensee developed P/P for system to track the location of on-duty staff and sheltered residents; -Evidence the licensee developed P/P for shelter in place for residents, staff, and volunteers who remain in the facility; -Evidence the licensee developed P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -Evidence the licensee developed P/P to address: use of volunteers, including the process/role for integration; -Evidence the licensee developed a communication plan to include all of the following: method for sharing information from the	0 680		

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0 680	Continued From page 20 emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and -Evidence a communication plan was developed which included: -Method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care -Means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -Means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). On July 16, 2024, at 11:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not have backup supplies for shelter in place. LALD/CNS-A stated transportation for evacuation was not addressed in the EPP but they would use staff vehicles to transport residents. LALD/CNS-A stated they would review and update their EPP with the missing content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 21 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 22 Findings include: On July 16, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A. During the facility tour, it was observed the sleeping rooms that were equipped with smoke alarms were not interconnected upon testing, so the actuation of one alarm would cause all alarms to operate. During the interview on July 16, 2024, at 11:00 a.m., LALD/CNS-A stated the smoke alarms in the facility were not interconnected and the actuation of one alarm would not cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of	0 800		

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0 800	Continued From page 23 the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A. During the facility tour, survey staff observed the following items: In the living room on the first floor, it was observed that the gypsum ceiling had considerable brown stains from water damage. In sleeping room 4 on the lower level, it was observed that the egress window was obstructed by a plastic well cover that was installed lower than the window head. It was also observed a garden hose wheel cart was stored on top of the window well cover. During the facility tour, LALD/CNS-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 24	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee 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) Employees 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 employees 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 the interview and record review, the	0 810		

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0 810	Continued From page 25 licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, at 11:30 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP was a third-party consultant-provided plan, and it was not updated to meet the facility-specific layout. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on July 16, 2024, at 12:00	0 810		

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0 810	Continued From page 26 p.m., LALD/CNS-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols for staff and residents. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. Record review of the available documentation indicated the facility did not provide annual evacuation training for resident who are capable of assisting in their own evacuation. During the interview on July 16, 2024, at 12:00 p.m., LALD/CNS-A confirmed that the facility provided only one fire safety training for employees when hired and verified the facility did not provide annual FSEP training for the residents. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 5/28/24, 4/13/24, 2/8/24, 3/3/24 and 4/8/24, with no further drills being documented. During the interview on July 16, 2024, at 12:30 p.m., LALD/CNS-A stated there were no further documented drills for the facility prior to February 2024. LALD/CNS-A also stated the facility did not include evacuation practice as part of the provided as required by statute.	0 810		

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0 810	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied residents in bedrooms 1, 2, and 3 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems	0 820	This immediate correction order identified on July 16, 2024, has had the immediacy lifted as of July 16, 2024, however non-compliance remained a scope and level of I.	

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0 820	Continued From page 28 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 July 16, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom 3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 14.5 inches in height and 33 inches in width, with a total openable area of 478.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that unoccupied resident bedroom 2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 14.5 inches in height and 33 inches in width, with a total openable area of 478.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed unoccupied resident bedroom 1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 18 inches in height and 41inches in width, with a total openable area of	0 820		

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	37615	A. BUILDING: _____ B. WING _____	07/16/2024

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0 820	Continued From page 29 738 square inches. The windows did not meet the minimum requirements for opening height. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD/CNS-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD/CNS-A verbally confirmed the findings. On July 16, 2024, at 11:00 a.m., during the interview, survey staff explained to LALD/CNS-A that an immediate correction order was issued for the above finding. LALD/CNS-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must:	0 900		

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0 900	Continued From page 30 (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 was admitted to the licensee on January 25, 2023. R2 was a resident at another assisted living	0 900		

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0 900	Continued From page 31 facility (a sister facility to the licensee) prior to their admission to the licensee. R2's record included an Assisted Living Contract signed on February 18, 2022. The contract was from when they were admitted to the sister facility prior to their admission to the current licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation and transportation. On July 16, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R2. On July 15, 2024, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was a transferred resident from one of their sister facilities in 2022. The surveyor explained a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. LALD/CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses and a new contract would need to be completed upon admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		

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01440	Continued From page 32	01440		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-C). 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	01440		

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01440	Continued From page 33 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on February 25, 2022, to provide direct cares to residents. ULP-B's employee record lacked evidence a RN 30-day supervision was completed. ULP-C ULP-C was hired on July 2, 2021, to provide direct cares to residents. ULP-C's employee record lacked evidence a RN 30-day supervision was completed. On July 16, 2024, at 9:02 a.m., the surveyor observed ULP-B administer medication to R2. On July 16, 2024, at 8:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not complete a RN 30-day supervision for ULP-B. On July 16, 2024, at 9:00 a.m., LALD/CNS-A stated they did not complete a RN 30-day supervision for ULP-C. LALD/CNS-A stated they were not completing RN 30-day supervisions for any of their ULPs. LALD/CNS-A stated they were aware RN 30-day supervisions were required but had been forgetting to complete them. On July 16, 2024, at 9:45 a.m., ULP-B stated they were unsure if they had received their RN 30-day supervision.	01440		

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01440	Continued From page 34 The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated, "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 35 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for three of three	01500		

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01500	Continued From page 36 employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD/CNS-A LALD/CNS-A was hired on February 17, 2019, to perform administrative duties, clinical duties, and to provide oversight to unlicensed personnel. LALD/CNS-A's employee record included an Educare (an online training platform) transcript which lacked evidence at least eight hours of annual training was completed every 12 months of employment to include the following topics: -reporting maltreatment of vulnerable adults or minors; -assisted living bill of rights; and -infection control techniques. ULP-B ULP-B was hired on February 25, 2022, to provide direct cares to residents. ULP-B's employee record included an Educare (an online training platform) transcript which lacked evidence at least eight hours of annual training was completed every 12 months of employment to include the following topics: -effective approaches to use to problems solve	01500		

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01500	Continued From page 37 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and -review of provider's policies and procedures. ULP-C ULP-C was hired on July 2, 2021, to provide direct cares to residents. ULP-C's employee record included an Educare (an online training platform) transcript which lacked evidence at least eight hours of annual training was completed every 12 months of employment to include the following topics: -infection control techniques: and -review of provider policies and procedures. On July 15-16, 2024, the surveyor observed LALD/CNS-A performing their duties throughout the survey. On July 16, 2024, at 9:02 a.m., the surveyor observed ULP-B administer medication to R2. On July 16, 2024, at 8:38 a.m., LALD/CNS-A stated ULP-B had not completed training for all of the required annual training topics. LALD/CNS-A stated they used Educare for all of their employee annual training so if it wasn't completed in Educare then the employee did not complete the training. On July 16, 2024, at 9:45 a.m., ULP-B stated they received their initial orientation training but was unsure if they had received all of their annual training. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated:	01500		

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01500	Continued From page 38 "12. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 13. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization's policies and procedures related to provision of assisted living services and how to implement them d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC***** ii. Hand washing techniques iii. Need for/use of personal protective equipment (PPE), including: 1. Gloves 2. Gowns 3. Masks iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases e. Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff." No further information was provided.	01500		

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01500	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=E	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 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 provide employees with the initial eight (8) hours of dementia training within 160 hours of providing direct care to	01530		

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01530	Continued From page 40 residents for one of three direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired on February 25, 2022, to provide direct cares to residents. ULP-B's employee record lacked at least eight hours of initial dementia training completed within 160 hours of providing direct care to residents. ULP-C's Educare (an online training platform) transcript indicated ULP-B completed 5.25 hours of dementia training. ULP-B's employee record included an Assisting Clients with Alzheimer's & Dementia with Activities of Daily Living Post Test form dated June 26, 2022. It was a knowledge test completed by ULP-B and lacked time spent on the training. ULP-C ULP-C was hired on July 2, 2021, to provide direct cares to residents. ULP-C's employee record lacked eight hours of initial dementia training completed within 160 hours of providing direct care to residents.	01530		

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01530	Continued From page 41 ULP-C's Educare transcript indicated ULP-C completed 4.75 hours of dementia training. On July 16, 2024, at 9:02 a.m., the surveyor observed ULP-B administer medication to R2. On July 16, 2024, at 8:38 a.m., LALD/CNS-A stated ULP-B had not completed training for all of the required annual training topics. LALD/CNS-A stated they used Educare for all of their employee annual training so if it wasn't completed in Educare then the employee did not complete the training. On July 16, 2024, at 9:45 a.m., ULP-B stated they were unsure if they had received all of their all of their dementia training. The licensee's Dementia Education policy dated August 1, 2021, indicated: "3. Direct care employees must have completed at least eight (8) hours of initial education** within 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (AOL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01610	Continued From page 42	01610		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment completed on or before their move in date 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 of the residents).	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37615	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	3264 XENIA AVENUE NORTH CRYSTAL, MN 55422

(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
01610	Continued From page 43 The findings include: R2 was admitted to the licensee on January 25, 2023. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's record included an Assisted Living Contract signed on February 18, 2022. The contract was from when they were admitted to the sister facility prior to their admission to the current licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation, and transportation. The service plan was from when they were a resident at the sister facility prior to their admission to the current licensee. R2's record included a Nurse Reassessment Visit form dated March 4, 2023. The form was a comprehensive nursing assessment labeled as a 90-day assessment. R2's record lacked an initial comprehensive nursing assessment completed on or before their move in date (January 25, 2023). On July 16, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R2. On July 15, 2024, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was a transferred resident from one of their sister facilities in 2022. The surveyor explained a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the	01610		

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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
01610	Continued From page 44 previous licensee then admitted to the current licensee. LALD/CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses and a new admission assessment was required. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated, "The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
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	01620		

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01620	Continued From page 45 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment within 14 days of the initiation of services for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 was admitted to the licensee on January 25, 2023. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's record included an Assisted Living Contract signed on February 18, 2022. The contract was from when they were admitted to the sister facility	01620		

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01620	Continued From page 46 prior to their admission to the current licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation, and transportation. The service plan was from when they were a resident at the sister facility prior to their admission to the current licensee. R2's record included a Nurse Reassessment Visit form dated March 4, 2023. The form was a comprehensive nursing assessment labeled as a 90-day assessment. R2's record lacked a 14-day comprehensive nursing assessment completed within 14 days of the initiation of services. On July 16, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R2. On July 15, 2024, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was a transferred resident from one of their sister facilities in 2022. The surveyor explained a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. LALD/CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses and a new 14-day assessment was required. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated, "The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services."	01620		

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01620	Continued From page 47 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a current signed service plan which identified specific services to be provided for one of one resident (R2).	01640		

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01640	Continued From page 48 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on January 25, 2023. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's record included an Assisted Living Contract signed on February 18, 2022. The contract was from when they were admitted to the sister facility prior to their admission to the current licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation, and transportation. The service plan was from when they were a resident at the sister facility prior to their admission to the current licensee. On July 16, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R2. On July 15, 2024, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was a transferred resident from one of their sister facilities in 2022. The surveyor explained a resident could not be	01640		

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01640	Continued From page 49 "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. LALD/CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses and a new service plan was required to be completed. The licensee's Service Plan policy dated August 1, 2021, indicated, "Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications,	01700		

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01700	Continued From page 50 allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse (RN) prior to providing medication management services for one of one resident (R2) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on January 25, 2023. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee.	01700		

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01700	Continued From page 51 R2's record included an Assisted Living Contract signed on February 18, 2022. The contract was from when they were admitted to the sister facility prior to their admission to the current licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation, and transportation. The service plan was from when they were a resident at the sister facility prior to their admission to the current licensee. R2's Medication Administration Record (MAR) for July 2024, indicated the following medications were administered to R2 on July 1-15, 2024: -acetaminophen 500 milligram (mg) tablet, take two tablets (1000mg) by mouth (PO) as needed (PRN) for pain; -amlodipine besylate 10mg tablet, take one tablet by mouth (PO) once daily; -bisacodyl suppository 10mg, insert one suppository rectally once daily PRN; -diclofenac gel 1%, apply 4 grams (g) topically to right ankle four times daily as needed for pain; -Gavilax powder; take 17g in liquid and drink PO once daily PRN for constipation; -folic acid 1mg tablets; take one tablet PO once daily; -glipizide extended release (ER) 5mg tablet, take one tablet by PO once daily; -Humira injection pen 50mg/0.4 milliliters (ml), inject one dose (40mg) subcutaneously (SQ) every two weeks; -lactulose solution 10 gram (g)/15 ml, take 30ml PO once daily; -lacosamide 200mg tablet, take one tablet PO twice daily; -levetiracetam 500mg tablet, take one tablet PO	01700		

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01700	Continued From page 52 twice daily; -levothyroxine 125 microgram (mcg) tablet, take one tablet PO once daily; -losartan/hydrochlorothiazide 100mg/12.5mg tablet, take one tablet PO once daily; -meloxicam 15mg tablet, take one tablet PO once daily; -metformin 500mg ER tablet, take two tablets (1000mg) PO twice daily; -methotrexate 2.5mg tablet, take seven tablets (17.5mg) PO once a week, must take all seven tablets on the same day; -Milk of Magnesia 473ml, take 30ml PO once daily PRN for constipation; -olanzapine 15mg tablet, take one tablet PO at bedtime (HS); -omeprazole 20mg capsule, take one capsule PO once daily; -oyster shell 500mg tablet, take one tablet PO twice daily; -pravastatin 40mg tablet, take one tablet PO at HS; -Refresh P.M. optical ointment, apply a small amount in both eyes at HS; -risperidone 4mg tablet, take one tablet PO at HS; -Senexon-s 8.6-50mg tablet, take one tablet PO twice daily; -sertraline 100mg tablet, take one tablet PO once daily; and -vitamin D3 25mcg (1000 units (u)) capsule, take one capsule PO once daily. R2's record lacked a medication management assessment completed prior to providing medication management services upon admission to the licensee on January 25, 2023. On July 16, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-B	01700		

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01700	Continued From page 53 administer medication to R2. On July 15, 2024, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was a transferred resident from one of their sister facilities in 2022. The surveyor explained a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. LALD/CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses and a new medication management assessment was required. The licensee's Assessment of Medications policy dated August 1, 2021, indicated, "Prior to providing medication management services, [Licensee] will provide an assessment by a registered nurse (RN) to determine what medication management services will be provided and how they will be implemented." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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01730	Continued From page 54 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete an individualized medication management plan for one of one resident (R2) receiving medication	01730		

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01730	Continued From page 55 management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on January 25, 2023. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's record included an Assisted Living Contract signed on February 18, 2022. The contract was from when they were admitted to the sister facility prior to their admission to the current licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation and transportation. The service plan was from when they were a resident at the sister facility prior to their admission to the current licensee. R2's Medication Administration Record (MAR) for July 2024, indicated the following medications were administered to R2 on July 1-15, 2024: -acetaminophen 500 milligram (mg) tablet, take two tablets (1000mg) by mouth (PO) as needed (PRN) for pain; -amlodipine besylate 10 milligrams (mg) tablet, take one tablet by mouth (PO) once daily;	01730		

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01730	Continued From page 56 -bisacodyl suppository 10mg, insert one suppository rectally once daily PRN; -diclofenac gel 1%, apply 4 grams (g) topically to right ankle four times daily as needed for pain; -Gavilax powder; take 17g in liquid and drink PO once daily PRN for constipation; -folic acid 1mg tablets; take one tablet PO once daily; -glipizide extended release (ER) 5mg tablet, take one tablet by PO once daily; -Humira injection pen 50mg/0.4 milliliters (ml), inject one dose (40mg) subcutaneously (SQ) every two weeks; -lactulose solution 10 gram (g)/15 ml, take 30ml PO once daily; -lacosamide 200mg tablet, take one tablet PO twice daily; -levetiracetam 500mg tablet, take one tablet PO twice daily; -levothyroxine 125 microgram (mcg) tablet, take one tablet PO once daily; -losartan/hydrochlorothiazide 100mg/12.5mg tablet, take one tablet PO once daily; -meloxicam 15mg tablet, take one tablet PO once daily; -metformin 500mg ER tablet, take two tablets (1000mg) PO twice daily; -methotrexate 2.5mg tablet, take seven tablets (17.5mg) PO once a week, must take all seven tablets on the same day; -Milk of Magnesia 473ml, take 30ml PO once daily PRN for constipation; -olanzapine 15mg tablet, take one tablet PO at bedtime (HS); -omeprazole 20mg capsule, take one capsule PO once daily; -oyster shell 500mg tablet, take one tablet PO twice daily; -pravastatin 40mg tablet, take one tablet PO at HS;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37615	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	3264 XENIA AVENUE NORTH CRYSTAL, MN 55422

(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
01730	Continued From page 57 -Refresh P.M. optical ointment, apply a small amount in both eyes at HS; -risperidone 4mg tablet, take one tablet PO at HS; -Senexon-s 8.6-50mg tablet, take one tablet PO twice daily; -sertraline 100mg tablet, take one tablet PO once daily; and -vitamin D3 25mcg (1000 units (u)) capsule, take one capsule PO once daily. R2's record lacked an individualized medication management plan when they began receiving medication management services upon admission to the licensee on January 25, 2023. On July 16, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R2. On July 15, 2024, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was a transferred resident from one of their sister facilities in 2022. The surveyor explained a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. LALD/CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses and a new individualized medication management plan was required. The licensee's Assessment of Medications policy dated August 1, 2021, indicated: "f. Based on the results of the assessment, the RN will document an individualized medication management plan, including the following elements	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37615	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01730	Continued From page 58 i. Description of medication management services to be provided ii. Description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction iii. Documentation procedures iv. Procedures for verification that medications are administered as prescribed v. Procedures for monitoring medication use to prevent complications or adverse reactions vi. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered in a timely manner vii. Identification of medication management tasks delegated to unlicensed staff viii. Procedures for notifying the registered nurse or licensed health profession regarding problems arising with medication management services." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for one of	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37615	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 59 one resident (R2) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on January 25, 2023. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation and transportation. The service plan was from when they were a resident at the sister facility prior to their admission to the current licensee. R2's Medication Administration Record (MAR) for July 2024, indicated R2 took the following medication which was administered to R2 on July 10, 2024: -Humira injection pen 50mg/0.4 milliliters (ml), inject one dose (40mg) subcutaneously (SQ) every two weeks. On July 15, 2024, at 10:17 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed the medication refrigerator which included classic thermometer which indicated a	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37615	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 60 temperature of 40 degrees Fahrenheit (F). LALD/CNS-A stated they did not have a temperature log for the medication refrigerator. LALD/CNS-A stated they were aware a temperature log was needed and stated they worked in a nursing home where it was required as well. The surveyor observed the following medication in the medication refrigerator: -R2's Humira injection pen 50mg/0.4 milliliters (ml), inject one dose (40mg) subcutaneously (SQ) every two weeks; one of two injection pens were left in the box. Manufacturer instructions for Humira indicated to store Humira in the refrigerator between 36- and 46-degrees F. Do not freeze Humira or use if it has been frozen. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated, "Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37615	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02240	Continued From page 61 understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by:	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37615	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	3264 XENIA AVENUE NORTH CRYSTAL, MN 55422

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02240	Continued From page 62 Based on observation, interview, and record review, the licensee failed to ensure a written acknowledgement of receipt of the current assisted living bill of rights was obtained for one of one resident (R2). 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: R2 was admitted for assisted living services on January 25, 2023. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan dated October 24, 2022, indicated R2 received services for medication administration, bathing assistance, hygiene and grooming, dressing assistance, laundry, housekeeping, food preparation, and transportation. On July 16, 2024, at 9:02 a.m., the surveyor observed R2's medication administration performed by unlicensed personnel (ULP)-B. On July 15, 2024, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 was transferred from one of their sister facilities. On July 16, 2024, at 9:32 a.m., LALD/CNS-A stated they did provide the assisted living bill of	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02240	Continued From page 63 rights to R2 at the time of admission but was unable to locate the documentation. The licensee's Notifications policy dated August 1, 2021, indicated, "13. Journeys Home Care will obtain written acknowledgment of the resident's receipt of the assisted living bill of rights, notice of privacy and UDALSA from the resident or the resident's representative or document why an acknowledgment could not be obtained." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *07/15/24*
Time: 12:07:39
Report: 7994241134

Food and Beverage Establishment Inspection Report

Location:

Journeys Home Care Llc
3264 Xenia Avenue North
Crystal, MN55422
Hennepin County, 27

Establishment Info:

ID #: 0038584
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122024007
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

SEVERAL CONDIMENTS FOUND IN CUPBOARD THAT REQUIRE REFRIGERATION AFTER OPENING. DISCARD THESE AND ENSURE OTHER BOTTLES REMAIN IN FRIDGE ONCE OPENED.

Comply By: 07/15/24

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

THERE WAS NO APPROVED WAY TO TEST THE INTERNAL TEMPERATURE OF THE DISHWASHER FOUND ON SITE. PROVIDE AN APPROVED THERMOMETER OR TEST STRIPS.

Comply By: 07/15/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NEITHER OF THE TWO COMPARTMENTS OF THE SINK ARE DESIGNATED AS THE HANDWASH SINK.

Comply By: 07/15/24

Type: Full
Date: *07/15/24*
Time: 12:07:39
Report: 7994241134
Journeys Home Care Llc

Food and Beverage Establishment Inspection Report

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND POPCORN TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT 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 7994241134 of 07/15/24.

Certified Food Protection Manager Renee Ndubisi

Certification Number: 120430 Expires: 12/13/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Joseph Ndubisi
Director

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241134

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2	**Date**	07/15/24
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:07:39
Legal Authority MN Rules Chapter 4626		**Time Out**	

Journeys Home Care Llc	**Address** 3264 Xenia Avenue North	**City/State** Crystal, MN	**Zip Code** 55422	**Telephone** 6122024007
License/Permit # 0038584	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/15/24

Inspector (Signature) Crystal Elva