DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 10, 2022

Administrator
New Journey Residence
100 Vermilion Trail
Biwabik, MN 55708

RE: Project Number(s) SL21987015

Dear Administrator:

On May 2, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the March 9, 2022, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

Electronically Delivered

March 25, 2022

Administrator
New Journey Residence
100 Vermilion Trail
Biwabik, MN 55708

RE: Project Number(s) SL21987015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 . . ."

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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21987	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	100 VERMILION TRAIL BIWABIK, MN 55708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL#21987015 On March 7, 2022, through March 9, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 27 residents, all of whom were receiving services under the provider's Assisted Living with Dementia Care license. The immediate correction order(s) tag identification 2310, identified on March 9, 2022, has been corrected as of March 9, 2022. No further action required.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all the required content for two of two employees (unlicensed personnel (ULP)-C, ULP-D) with employee records reviewed. This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 2 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 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-C ULP-C was hired September 1, 2021, to provide direct care and services to the licensee's residents. On March 8, 2022, at approximately 8:45 a.m., ULP-C was observed administering medication to R10. ULP-C's employee file lacked the following required content: -records of orientation to include: -an overview of the appropriate Assisted Living statutes and rules; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-D ULP-D was hired on January 5, 2018, to provide direct care and services to the licensee's residents under the comprehensive home care license and began providing services under the assisted living licensure on August 1, 2021.	0 650		

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0 650	Continued From page 3 ULP-D's employee file lacked the following required content: -records of orientation to include: -an overview of the appropriate Assisted Living statutes and rules; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On March 8, 2022, at approximately 8:30 a.m., registered nurse (RN)-A stated she reviews assisted living regulations and the licensee's Uniform Disclosure of Assisted Living Services and Amenities during orientation with new hires. RN-A confirmed the documentation in ULP-C and ULP-D employee files did not indicate orientation to assisted living regulations was completed but confirmed it was covered during all new hire orientation. The licensee's undated policy, Orientation of Staff, indicated evidence of the completion of required orientation topics must be kept in the employee record of each staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 4 (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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z with records reviewed. 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).	0 680		

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0 680	Continued From page 5 The findings include: On March 7, 2022, at approximately 2:00 p.m., the surveyor requested the licensee's emergency preparedness plan (EPP), which was later reviewed by the surveyor. The plan contained a binder of various emergency situations, including how staff should respond. The licensee's policies included direction on making an emergency plan, and the policies listed various emergency situations (such as heat, several weather emergencies, emergency evacuations, plan activations); however, the procedures spelled out in the plan were generic, lacking specificity to the licensee. The licensee's plan lacked the following required content: -all hazards based emergency preparedness program with a risk assessment considering all hazards that may impact all or a portion of the facility; -an assessment of the at risk population's needs; -a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations; -policies and procedures that are stored in a central place; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies and procedures, based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents -transfer agreements and/or contracts with other facilities/providers to receive residents in the	0 680		

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0 680	Continued From page 6 event of evacuation or other limitations that would impact the continuity of services; -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. On March 8, 2022, at approximately 10:15 a.m., executive director (ED)-B confirmed the EPP was lacking some of the required content. The licensee's undated policy, Evacuation and Disaster Plan, indicated the licensee would have a written emergency and disaster plan. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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0 730	Continued From page 7	0 730		

the resident's emergency contact, legal representatives, and designated representative;
(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;
(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;
(5) the resident's advance directives, if any;
(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;
(7) the facility's current and previous assessments and service plans;
(8) all records of communications pertinent to the resident's services;
(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(11) documentation that services have been provided as identified in the service plan;
(12) documentation that the resident has received and reviewed the assisted living bill of rights;
(13) documentation of complaints received and any resolution;
(14) a discharge summary, including service termination notice and related documentation, when applicable; and
(15) other documentation required under this chapter and relevant to the resident's services or

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0 730	Continued From page 8 status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R4), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 admitted to services on January 1, 2021, and discharged on October 11, 2021. R4's record contained a progress note that indicated the resident had discharged due to needing a higher level of care but lacked the following required content: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; and -a postdischarge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the	0 730		

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0 730	Continued From page 9 resident adjust to a new living environment. The postdischarge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any postdischarge medical and nonmedical services the resident will need. On March 7, 2022, at approximately 3:00 p.m., registered nurse (RN)-A confirmed the discharge summary lacked all of the required content. The licensee's undated Client (resident) Records policy indicated the record would contain a discharge summary with related documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 730		
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.	0 800		

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0 800	Continued From page 10 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 March 9, 2022, between 10:30 a.m. and 12:00 p.m, survey staff toured the facility with the registered nurse (RN)-A and the maintenance manager (MM)-I. During the facility tour, survey staff observed the following: 1. The inspection tag for the fire sprinkler system was dated 11-05-2020. The MM-I confirmed during the tour interview that the sprinkler system required service. 2. There were stained and missing ceiling tiles in multiple locations throughout the basement. The RN-A explained during the tour interview that ceiling tiles were stained from water damage and confirmed that ceiling tiles were missing in several areas of the basement. 3. A laundry room smoke detector was loose and not mounted securely to the ceiling. The RN-A confirmed during the tour interview that the smoke detector required repair. 4. A chain lock was installed on the emergency exit door in the basement activity room. The RN-A confirmed during the tour interview that this chain lock required removal. 5. There was an electrical circuit breaker panel on the wall without a cover in the unlocked storage room located adjacent to the living area in the dementia care unit. The RN-A confirmed during the tour interview that the electrical circuit breaker panel was not secure.	0 800		

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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
0 800	Continued From page 11 6. Two emergency exit doors on the main floor of the facility had signage posted that the exits were currently closed. The RN-A explained during the tour interview that these signs had been posted to limit travel through these exits to assist with screening for COVID. On March 9, between 12:55 p.m. and 1:20 p.m., during the exit interview with the executive director (ED)-B and the RN-A, it was confirmed that these signs required removal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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.	0 810		

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0 810	Continued From page 12 (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 document review and interview, the licensee failed to provide the required plans for fire safety and evacuation and staff training. 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 March 9, 2022, between 12:00 p.m. and 12:30 p.m., the registered nurse (RN)-A and the executive director (ED)-B, provided documents for review. Documents were reviewed by survey staff on March 9, 2022, between 12:00 p.m. and 12:50 p.m. 1. The Fire Policy failed to include: a. Plans with accurate instructions on fire protection procedures.	0 810		

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0 810	Continued From page 13 i. magnetic door holders were referenced, which the facility did not identify. ii. the policy referenced an alarm system wired directly to the fire station, but during the facility tour, the RN-A explained that the alarm system did not notify the fire department upon activation. b. Identification of unique or unusual resident needs for movement or evacuation. 2. The licensee failed to provide staff training for fire safety and evacuation at the required frequency. Staff training for fire safety and evacuation was completed during orientation and then annually but did not require training at least twice per year after hire. On March 9, 2022, between 12:55 p.m. and 1:20 p.m., during the exit interview with the ED-B and the RN-A, it was confirmed that the facility failed to provide the required content within the fire safety and evacuation plans. The RN-A explained procedures verbally for fire safety and evacaution that were not included within the written polices or plans. The ED-B and the RN-A also confirmed that the staff training frequency on the fire safety and evacuation plans was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or	0 970		

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0 970	Continued From page 14 unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 7, 2022, at approximately 2:00 p.m., an updated copy of the licensee's contract was requested. The contract included two clauses that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. Page 14, section 2, of the contract indicated a resident would indemnify or hold harmless the provider, it's employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or	0 970		

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0 970	Continued From page 15 omission of resident or resident's guests or agents. Page 14, section 4, of the contract indicated the provider was not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. On March 8, 2022, at approximately 9:15 a.m., licensed assisted living director (LALD)-E confirmed the contract used for all residents contained language that would waive the facility's liability for health, safety, or personal property of a resident. A policy on content of assisted living contracts was requested, but not provided. No further information was provided. Time period for correction: Twenty-one (21) days	0 970		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-F and ULP-H) were oriented specifically to one of one resident (R2),	01480		

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01480	Continued From page 16 with records reviewed. 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's diagnoses included chronic obstructive pulmonary disease (COPD), stage 5 chronic kidney disease, and muscle weakness. R2's service plan, dated December 2, 2021, indicated the resident received the following services: assistance with bathing and dressing, monthly nail care from the nurse, weekly weight, weekly housekeeping and laundry, medication administration, supervision with toileting, and assistance with nebulizers. R2 received dialysis three times per week at an outside provider, and had a fistula (access site for dialysis) in his left forearm. On March 8, 2022, at approximately 12:45 p.m., ULP-F stated staff are not instructed to monitor the fistula site and dialysis is usually responsible for monitoring it. ULP-F stated she wasn't sure what would be considered an emergency with the fistula but if the site began bleeding, ULP-F stated they would contact the nurse. On March 8, 2022, at approximately 12:50 p.m., ULP-H stated she hadn't had any official training on what would be considered an emergency	01480		

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01480	Continued From page 17 situation with R2's fistula. ULP-H stated if it was bleeding really bad, she would call the nurse for further directions. ULP-H stated R2 would notify staff if there were any issues with his fistula. On March 8, 2022, at approximately 1:25 p.m., registered nurse (RN)-A stated dialysis would update them if there were any issues or changes with the fistula and they send a communication tool back when he returns from dialysis. RN-A stated if R2 was bleeding non-stop, staff would call her or call 911. The licensee's undated policy, Hospice and Dialysis, indicated staff would be trained in the care and monitoring of the dialysis access site and emergency procedures pertaining to the access site. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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	01540		

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01540	Continued From page 18	01540		

meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training in the required time frame with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

The licensee had a current assisted living facility with dementia care license.

ULP-C was hired on September 1, 2021, to provide direct care services to the licensee's residents.

On March 8, 2022, at approximately 8:45 a.m., ULP-C was observed administering medication to R10.

ULP-C's employee records did not contain

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01540	Continued From page 19 documentation of the required eight (8) hours of training on the specific dementia care topics within 80 working hours of their respective hire dates. ULP-C's record indicated she had completed approximately 7.5 hours of dementia training. On March 8, 2022, at approximately 10:25 a.m., executive director (ED)-B confirmed ULP-C was short by approximately 30 minutes. The licensee's undated policy, Additional Dementia Staff Training, indicated staff who work with residents who have Alzheimer's disease and other dementias have proper training for the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01540		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained, including the expiration date for time sensitive medications, for two of two residents (R1, R11) with records reviewed.	01890		

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01890	Continued From page 20	01890		

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 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:

R1
On March 7, 2022, at approximately 7:00 p.m., the locked first floor medication room was reviewed with unlicensed personnel (ULP)-G. The following was observed and confirmed by ULP-G:

R1's Novolog (short-acting insulin) and Basaglar (long-acting insulin) lacked a label which indicated the date the pens were opened. The pens contained a label that indicated to discard after 28 days with the space to enter the date left blank.

ULP-G stated she was not sure when the pens had been opened.

The manufacturer's instructions for the use of Novolog, dated December 2012, directed open pens stored at room temperature should be discarded after 28 days.

The manufacturer's instructions for the use of Basaglar, dated July 2021, directed open pens should be discarded after 28 days.

R11

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01890	Continued From page 21 On March 8, 2022, at approximately 8:30 a.m., the locked first floor memory care medication room was reviewed with ULP-D. The following was observed and confirmed by ULP-D: R11's lantus (long-acting insulin) lacked a label which indicated the date the pens were opened. The pens contained a label that indicated to discard after 28 days with the space to enter the date left blank. ULP-D stated she was not sure when the pen had been opened. The manufacturer's instructions for the use of Lantus, dated July 2015, directed open pens should be discarded after 28 days. On March 8, 2022, at approximately 1:20 p.m., registered nurse (RN)-A stated staff were directed to label pens with the date they were opened. RN-A stated sometimes staff might not label the pens when opened because one of the residents uses a full pen within a few days and they never last to 28 days. The licensee's undated Storage of Medications policy indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940		

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01940	Continued From page 22 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident for one of two residents (R1) receiving treatments. This practice resulted in a level two violation (a	01940		

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01940	Continued From page 23	01940		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's diagnoses included bipolar disorder, depression, and type two diabetes.

R1's service plan, dated January 25, 2021, indicated the resident received the following services: assistance with bathing, dressing, grooming, toileting, and transfers, daily skin check for bruising/redness/open areas with application of barrier cream after toileting, weekly housekeeping and laundry, medication administration, blood glucose monitoring, and insulin administration. R1's service plan lacked wound care services.

R1's most recent assessment, dated January 10, 2022, indicated the resident had a chronic open area to her right buttock with barrier cream applied daily.

R1's signed prescriber orders, dated February 23, 2022, directed staff to apply a Mepilex AG foam to buttock wound daily.

R1's treatment management plan listed instructions on the resident's March 2022 medication administration record (MAR) to place a Mepilex AG 4x4 dressing over the right buttock and right thigh.

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01940	Continued From page 24 On March 8, 2022, at approximately 1:05 p.m., unlicensed personnel (ULP)-H was observed toileting R1. R1 was observed to have a Mepilex AG 4x4 dressing in place to her buttock. On March 8, 2022, at approximately 1:30 p.m., registered nurse (RN)-A confirmed R1's wound care services were not included on the service plan. A policy regarding content of the service plan was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or	02040		

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NEW JOURNEY RESIDENCE	100 VERMILION TRAIL BIWABIK, MN 55708

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02040	Continued From page 25 safety risk assessment that included hazards identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. 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 March 9, 2022, between 12:00 p.m. and 12:30 p.m., the registered nurse (RN)-A and the executive director (ED)-B, provided documents for review. Documents were reviewed by survey staff on March 9, 2022, between 12:00 p.m. and 12:50 p.m. The Hazard Vulnerability Assessment did not include hazards or safety risks identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. On March 9, 2022, between 12:55 p.m. and 1:20 p.m., the ED-A confirmed during the exit interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. They also confirmed that mitigation of property hazards to protect residents from harm had not been included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21987	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	100 VERMILION TRAIL BIWABIK, MN 55708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 26	02310		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for six of six residents (R2, R3, R6, R7, R8, R9) with bedrails. This resulted in an immediate correction order on March 7, 2022, at approximately 4:30 p.m. 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: R2 On March 7, 2022, at approximately 3:30 p.m., the surveyor observed a bedrail on the right side near the head of the resident's bed. The bedrail was secured to the bed frame. R2's diagnoses included chronic obstructive pulmonary disease (COPD), stage 5 chronic kidney disease, and muscle weakness.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21987	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	100 VERMILION TRAIL BIWABIK, MN 55708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 27 R2's service plan, dated December 2, 2021, indicated the resident recieved the following services: assistance with bathing and dressing, monthly nail care from the nurse, weekly weight, weekly housekeeping and laundry, medication administration, supervision with toileting, and assistance with nebulizers. On March 7, 2022, at approximately 3:35 p.m., registered nurse (RN)-A stated the bedrail was to assist with turning and transferring out of bed and the resident could independently raise and lower the side rail. RN-A measured the bed rail with the surveyor present. The bed rail measured 36 inches wide by 18 inches tall. The gap between the rails was 3 inches, which was in compliance with FDA guidelines for bed rails. RN-A confirmed an assessment for the bed rail had not been completed. RN-A confirmed there was not documentation of a review of risks and benefits for the resident's use of siderails. R3 On March 7, 2022 at approximately 3:20 p.m., the surveyor observed a bedrail on the right side near the head of the resident's bed. The bedrail was an open loop style which was held between the mattress and box spring, but did not secure to the bed frame or any other surface. R3's diagnoses included adult failure to thrive. R3's service plan, dated July 8, 2021, indicated the resident received the following services: monthly B12 (vitamin) injection, assistance with ambulation and bathing, reminders/verbal cues, supervision with grooming and dressing, weekly housekeeping and laundry, and assistance with toileting.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21987	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	100 VERMILION TRAIL BIWABIK, MN 55708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 28 On March 7, 2022 at approximately 3:25 p.m., RN-A stated the bedrail was to assist with turning and transferring out of bed and the resident had brought the rail in when she admitted to the facility. RN-A stated since the rail was brought in and the resident could show she was safe to use the side rail independently, no further assessments were completed. RN-A measured the bed rail with the surveyor present. The bed rail measured 12 inches wide and 17 inches tall. The gap between the mattress and the top of the bed rail was 13.5 inches. R3 confirmed she used the side rail to get in and out of bed. RN-A confirmed an assessment for the bed rail had not been completed. RN-A confirmed there was not documentation of a review of risks and benefits for the resident's use of siderails. R6 On March 7, 2022, at approximately 3:40 p.m., the surveyor observed a bedrail on the right side near the head of the resident's bed. The bedrail was secured to the bed frame. R6's diagnoses included dementia. R6's service plan, dated August 19, 2021, indicated the resident received the following services: assistance with bathing and dressing, reminders/verbal cues, weekly housekeeping and laundry, medication set up and administration, and supervision with toileting. On March 7, 2022, at approximately 3:45 p.m., RN-A stated the bedrail was to assist with turning and transferring out of bed. RN-A measured the bed rail with the surveyor present. The bed rail measured 36 inches wide by 18 inches tall. The gap between the rails was 3 inches, which was in	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21987	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	100 VERMILION TRAIL BIWABIK, MN 55708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 29	02310		

compliance with FDA guidelines for bed rails. R6 confirmed she utilized the bed rail for positioning and getting in and out of bed. RN-A confirmed an assessment for the bed rail had not been completed. RN-A confirmed there was not documentation of a review of risks and benefits for the resident's use of siderails.

R7
On March 7, 2022, at approximately 3:50 p.m., the surveyor observed a bedrail on the right side near the head of the resident's bed. The bedrail was secured to the bed frame.

R7's diagnoses included Parkinson's disease.

R7's service plan, dated July 13, 2021, indicated the resident received the following services: assistance with bathing and dressing, behavior management/redirection, and assistance with transferring.

On March 7, 2022, at approximately 3:55 p.m., RN-A stated the bedrail was to assist with turning and transferring out of bed. RN-A measured the bed rail with the surveyor present. The bed rail measured 36 inches wide by 18 inches tall. The gap between the rails was 3 inches, which was in compliance with FDA guidelines for bed rails. RN-A confirmed an assessment for the bed rail had not been completed. RN-A confirmed there was not documentation of a review of risks and benefits for the resident's use of siderails.

R8
On March 7, 2022, at approximately 4:00 p.m., the surveyor observed a bedrail on the left side near the head of the resident's bed. The bedrail was secured to the bed frame.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21987	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	100 VERMILION TRAIL BIWABIK, MN 55708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 30 R8's diagnoses included COPD. R8's service plan, dated December 6, 2021, indicated the resident received the following services: assistance with bathing, dressing, and grooming, reminders/verbal cues, behavior management/redirection, monthly nail care from the RN, weekly housekeeping and laundry, medication assistance, and assistance with oxygen. On March 7, 2022, at approximately 4:05 p.m., RN-A stated the bedrail was to assist with turning and transferring out of bed. RN-A measured the bed rail with the surveyor present. The bed rail measured 36 inches wide by 18 inches tall. The gap between the rails was 3 inches, which was in compliance with FDA guidelines for bed rails. RN-A confirmed an assessment for the bed rail had not been completed. RN-A confirmed there was not documentation of a review of risks and benefits for the resident's use of siderails. R9 On March 7, 2022, at approximately 4:10 p.m., the surveyor observed a bedrail on the right side near the head of the resident's bed. The bedrail was secured to the bed frame. R9's diagnoses included Alzheimer's. R9's service plan, dated July 8, 2021, indicated the resident received the following services: assistance with toileting, assistance with medications, supervision with grooming, behavior management for hoarding/rummaging, and assistance with bathing. On March 7, 2022, at approximately 3:55 p.m.,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21987	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	100 VERMILION TRAIL BIWABIK, MN 55708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 31 RN-A stated the bedrail was to assist with turning and transferring out of bed. RN-A measured the bed rail with the surveyor present. The bed rail measured 36 inches wide by 18 inches tall. The gap between the rails was 3 inches, which was in compliance with FDA guidelines for bed rails. RN-A confirmed an assessment for the bed rail had not been completed. RN-A confirmed there was not documentation of a review of risks and benefits for the resident's use of siderails. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The licensee's undated Siderails policy indicated when bed rails were used, the RN would conduct an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail. The policy failed to address what the assessment would include and how the licensee would address side rails that did not meet FDA standards.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21987	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	**100 VERMILION TRAIL BIWABIK, MN 55708**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy of the order was resolved at 7:32 p.m. on March 7, 2022.	02310		

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/08/22*
Time: 10:30:00
Report: 8010221053

Food and Beverage Establishment Inspection Report

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

Establishment Info:
ID #: 0038664
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188654588
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: DISHWASHER SANITIZING RINSE-TEMP TAPE TURNED BLACK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 195 Degrees Fahrenheit - Location: HAMBURGER
Violation Issued: No

Process/Item: Cooking
Temperature: 187 Degrees Fahrenheit - Location: HAMBURGER
Violation Issued: No

Process/Item: Cooking
Temperature: 192 Degrees Fahrenheit - Location: MASHED POTATOES
Violation Issued: No

Process/Item: Cooking
Temperature: 188 Degrees Fahrenheit - Location: BRUSSEL SPROUTS
Violation Issued: No

Process/Item: Cooking
Temperature: 193 Degrees Fahrenheit - Location: GRAVY
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 23 Degrees Fahrenheit - Location: CHOPPED HAM-BEVERAGE AIR
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: COTTAGE CHEESE-BEVERAGE AIR
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: CHEESE TORTELLINI-BEVERAGE AIR
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK-MILK DISPENSER
Violation Issued: No

Process/Item: Undercounter cooler
Temperature: 34 Degrees Fahrenheit - Location: MILK-SUPERIOR
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK-TURE
Violation Issued: No

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

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

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

COMMENTS:

DISCUSSED THE USE OF RAW EGGS THAT ARE ONLY TO BE USED IN ONE RESIDENT'S SERVING AT A SINGLE MEAL IF THE EGGS ARE COMBINED, COOKED AND SERVED IMMEDIATELY OR IN BAKED GOODS THAT ARE THOROUGHLY COOKED IF EGGS ARE COMBINED AS AN INGREDIENT IMMEDIATELY BEFORE BAKING.

DISCUSSED THAT PASTEURIZED EGGS OR EGG PRODUCTS MUST BE SUBSTITUTED FOR RAW EGGS WHEN MORE THAN ONE EGG IS BROKEN, COMBINED AND NOT COOKED, BAKED, OR USED IMMEDIATELY.

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8010221053 of 03/08/22.

Certified Food Protection Manager: Michael J. Meyer

Certification Number: FM26302 Expires: 02/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Michael Meyer
Kitchen Manager

Signed: _____

8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010221053

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	03/08/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
New Journey Residence	100 Vermilion Trail	Biwabik, MN	55708	2188654588

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038664		Full		

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	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:** 03/09/22

Inspector (Signature)