



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 12, 2026

Licensee
New Journey Residence
303 Hat Trick Avenue
Eveleth, MN 55734

RE: Project Number SL20846016

Dear Licensee:

On April 8, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 31, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 6, 2026

Licensee
New Journey Residence
303 Hat Trick Avenue
Eveleth, MN 55734

RE: Project Number(s) SL20846016

Dear Licensee:

On January 13, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 31, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 31, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 31, 2025, found not corrected at the time of the January 13, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$1,000.00

The details of the violations noted at the time of this follow-up survey completed on January 13, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna', with a stylized flourish at the end.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/21/2025
NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 303 HAT TRICK AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL20846016-01 On 10/22/2025 , the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on 7/29/25. At the time of the survey, there were 16 residents; 16 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}			
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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.	{0 510}			

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{0 775}	Continued From page 3	{0 775}			
{0 775} SS=G	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. 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 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). Findings include: On a facility tour on October 22, 2025, from 10:15 a.m. to 11:00 a.m., with director of maintenance (DM)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room two. UNOCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room two emergency escape and rescue clear window opening measurements are 16.5 inches wide, 40 inches in height and 660 square inches in openable area. The window was measured with DM-C, and the surveyor present. The window did not meet the minimum	{0 775}			

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{0 775}	Continued From page 4 requirements for clear opening minimum width. It was explained to DM-C, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. The resident room is unoccupied currently. If the proposed fire sprinkler system is installed this tag will be rescinded. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. They have a proposal for a fire sprinkler system. If the fire sprinkler system is installed it would negate this tag. These deficient conditions were visually verified by DM-C, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Seven (7) days. On the same facility tour, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: SPECIAL EXIT DOOR LOCKING ARRANGEMENTS There was one marked exit door provided with delayed egress door hardware all other marked exit doors were provided with controlled egress	{0 775}			

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{0 775}	Continued From page 5 door locking hardware. The building was provided with a fire alarm system but not a fire sprinkler system. It was explained that buildings with controlled egress hardware installed on marked egress doors are required to be provided with fire sprinkler protection. There was not an emergency release switch installed in the nurse office or other approved location to immediately release all controlled egress and delayed egress exit doors in order for occupants to exit in the event of an emergency. They have a proposal to install magnetic locks on all doors and a remote switch to unlock all doors. CORRIDOR WALL REQUIREMENTS The corridor walls separating the resident rooms and other incidental use rooms such as offices had windows and other unprotected openings communicating with the corridor. The walls, doors and other openings such as windows from rooms communicating with the egress path corridor are required to be fire resistant rated and self-closing in buildings not provided with fire sprinkler protection. It was explained the corridors are required to be fire resistant rated with self-closing doors and other openings to prevent the passage of smoke and fire in accordance with MSFC in Minnesota Rules Chapter 7511. This has not been completed. They have a proposal for a fire sprinkler system. If the fire sprinkler system is installed it would negate this tag.	{0 775}			

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{0 775}	Continued From page 6 FIRE ALARM SYSTEM TESTING AND MAINTENANCE During the tour the testing and maintenance report documentation was requested indicating the fire alarm system was tested and compliant annually as required. On Thursday July 31, 2025, at 4:55 p.m., documentation was received by email of a tag indicating the fire alarm system was tested May 2, 2024, with no testing details included. The system was recently tested and the DM-C will email a copy of the report. Any noted deficiencies on this report shall be fixed. FIRE RESISTANT RATED DOORS The fire-resistant rated doors of resident sleeping rooms 1 and 2 did not automatically close and latch when tested for operation. There were also several fire-resistant rated doors held open with devices that did not release to automatically close upon detection of smoke. There was not an automatic closer installed on the corridor doors leading to the shower room and laundry room. It was explained that all existing fire-resistant rated doors are required to automatically close and latch. The fire-resistant rated doors are also required to automatically release to close and latch upon detection of smoke when a hold open device is used. There was a 90-minute fire-resistant rated metal door jamb with hinges on the jamb missing the fire-resistant rated door across the corridor near	{0 775}			

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{0 775}	Continued From page 7 resident sleeping room six. It was explained that existing fire-resistant rated doors and door jambs are required to be maintained as installed at the time of construction approval. The door was installed but did not close and latch under its own power and was open when the surveyor was present. TIME PERIOD FOR CORRECTION: Seven (7) days.	{0 775}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	{0 810}			

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STATE FORM 6899 1NEZ12 If continuation sheet 9 of 15

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{01500}	Continued From page 9 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: Not reviewed during this survey.	{01500}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	{01650}			

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{01650}	Continued From page 10 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01650}			
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed	{01820}			

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{01820}	Continued From page 11 medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01820}			
{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: Not reviewed during this survey.	{01880}			
{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: Not reviewed during this survey.	{01890}			
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	{01910}			

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{01910}	Continued From page 12 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01910}			
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	{01950}			

Minnesota Department of Health

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{01950}	Continued From page 13 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01950}			
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01970}			
{02320} SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced	{02320}			

Minnesota Department of Health

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{02320}	Continued From page 14	{02320}			
	by: Not reviewed during this survey.				
{02410} SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02410}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 4, 2025

Licensee
New Journey Residence
303 Hat Trick Avenue
Eveleth, MN 55734

RE: Project Number(s) SL20846016

Dear Licensee:

On October 21, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 31, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 31, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 31, 2025, found not corrected at the time of the October 21, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$1,000.00

The details of the violations noted at the time of this follow-up survey completed on October 21, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

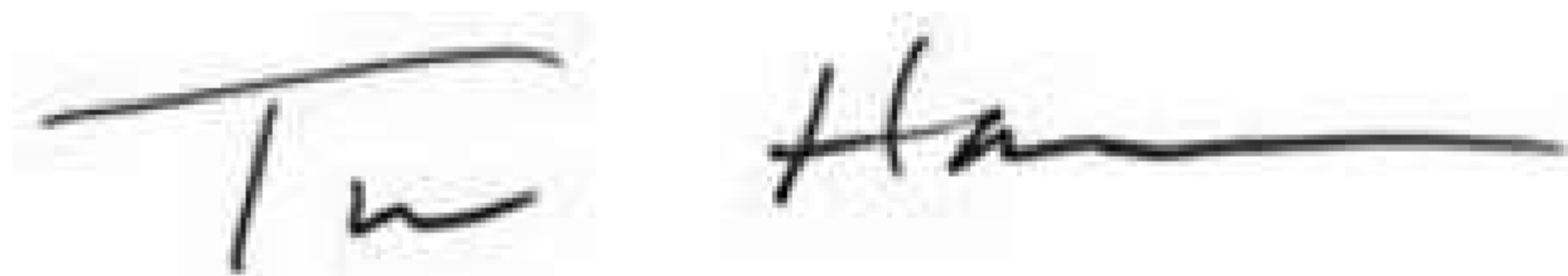
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna', is written over a light blue rectangular background.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/21/2025
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL20846016-01 On 10/22/2025 , the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on 7/29/25. At the time of the survey, there were 16 residents; 16 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}			
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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.	{0 510}			

Minnesota Department of Health

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{0 775}	Continued From page 3	{0 775}			
{0 775} SS=G	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. 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 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). Findings include: On a facility tour on October 22, 2025, from 10:15 a.m. to 11:00 a.m., with director of maintenance (DM)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room two. UNOCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room two emergency escape and rescue clear window opening measurements are 16.5 inches wide, 40 inches in height and 660 square inches in openable area. The window was measured with DM-C, and the surveyor present. The window did not meet the minimum	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 4 requirements for clear opening minimum width. It was explained to DM-C, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. The resident room is unoccupied currently. If the proposed fire sprinkler system is installed this tag will be rescinded. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. They have a proposal for a fire sprinkler system. If the fire sprinkler system is installed it would negate this tag. These deficient conditions were visually verified by DM-C, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Seven (7) days. On the same facility tour, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: SPECIAL EXIT DOOR LOCKING ARRANGEMENTS There was one marked exit door provided with delayed egress door hardware all other marked exit doors were provided with controlled egress	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 5 door locking hardware. The building was provided with a fire alarm system but not a fire sprinkler system. It was explained that buildings with controlled egress hardware installed on marked egress doors are required to be provided with fire sprinkler protection. There was not an emergency release switch installed in the nurse office or other approved location to immediately release all controlled egress and delayed egress exit doors in order for occupants to exit in the event of an emergency. They have a proposal to install magnetic locks on all doors and a remote switch to unlock all doors. CORRIDOR WALL REQUIREMENTS The corridor walls separating the resident rooms and other incidental use rooms such as offices had windows and other unprotected openings communicating with the corridor. The walls, doors and other openings such as windows from rooms communicating with the egress path corridor are required to be fire resistant rated and self-closing in buildings not provided with fire sprinkler protection. It was explained the corridors are required to be fire resistant rated with self-closing doors and other openings to prevent the passage of smoke and fire in accordance with MSFC in Minnesota Rules Chapter 7511. This has not been completed. They have a proposal for a fire sprinkler system. If the fire sprinkler system is installed it would negate this tag.	{0 775}			

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{0 775}	Continued From page 6 FIRE ALARM SYSTEM TESTING AND MAINTENANCE During the tour the testing and maintenance report documentation was requested indicating the fire alarm system was tested and compliant annually as required. On Thursday July 31, 2025, at 4:55 p.m., documentation was received by email of a tag indicating the fire alarm system was tested May 2, 2024, with no testing details included. The system was recently tested and the DM-C will email a copy of the report. Any noted deficiencies on this report shall be fixed. FIRE RESISTANT RATED DOORS The fire-resistant rated doors of resident sleeping rooms 1 and 2 did not automatically close and latch when tested for operation. There were also several fire-resistant rated doors held open with devices that did not release to automatically close upon detection of smoke. There was not an automatic closer installed on the corridor doors leading to the shower room and laundry room. It was explained that all existing fire-resistant rated doors are required to automatically close and latch. The fire-resistant rated doors are also required to automatically release to close and latch upon detection of smoke when a hold open device is used. There was a 90-minute fire-resistant rated metal door jamb with hinges on the jamb missing the fire-resistant rated door across the corridor near	{0 775}			

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{0 775}	Continued From page 7 resident sleeping room six. It was explained that existing fire-resistant rated doors and door jambs are required to be maintained as installed at the time of construction approval. The door was installed but did not close and latch under its own power and was open when the surveyor was present. TIME PERIOD FOR CORRECTION: Seven (7) days.	{0 775}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	{0 810}			

Minnesota Department of Health
STATE FORM 6899 1NEZ12 If continuation sheet 9 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/21/2025
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{01500}	Continued From page 9 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: Not reviewed during this survey.	{01500}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/21/2025
NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 303 HAT TRICK AVENUE EVELETH, MN 55734			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01650}	Continued From page 10 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01650}			
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed	{01820}			

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{01820}	Continued From page 11 medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01820}			
{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: Not reviewed during this survey.	{01880}			
{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: Not reviewed during this survey.	{01890}			
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	{01910}			

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{01910}	Continued From page 12 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01910}			
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	{01950}			

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{01950}	Continued From page 13 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01950}			
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01970}			
{02320} SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced	{02320}			

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{02320}	Continued From page 14	{02320}			
	by: Not reviewed during this survey.				
{02410} SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02410}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 17, 2025

Licensee
New Journey Residence
303 Hat Trick Avenue
Eveleth, MN 55734

RE: Project Number(s) SL20846016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2025, 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 . . ."

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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

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Minnesota Department of Health

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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: SL20846016-0 On July 29, 2025, through July 31, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 16 residents; 16 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 29, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for three of three employees (unlicensed personnel (ULP)-E, ULP-G, ULP-J) during personal cares. 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).	0 510			

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0 510	Continued From page 4 The findings include: On July 30, 2025, at 8:06 a.m., the surveyor observed ULP-E and ULP-J assist R3 with transferring and toileting. ULP-E and ULP-J put on gloves, applied the EZ-Stand (mechanical transfer device) sling, assisted R3 to a standing position with the use of EZ-Stand, pulled down R3's pants, removed R3's disposable brief and ULP-E washed R3's buttocks and perineal area with disposable wipes. Without changing gloves or performing hand hygiene, ULP-E and ULP-J put on a clean brief, pulled up R3's pants, transferred R3 into the recliner chair, and removed the EZ stand sling. ULP-E removed gloves, washed hands and ULP-J collected R3's garbage and exited R3's room wearing the same pair of gloves. On July 30, 2025, at 10:14 a.m., the surveyor observed ULP-G and ULP-J assist R2 with morning cares. R2 was lying in bed wearing a pajama shirt and a disposable brief. ULP-G and ULP-J put on gloves, ULP-G gathered R2's clean clothes and ULP-J washed R2's face. ULP-G and ULP-J removed R2's brief, ULP-G placed the soiled brief on the floor and ULP-G washed and dried R2's perineal area, buttocks and put on a clean brief. Without changing gloves or performing hand hygiene, ULPs removed R2's pajama shirt, applied deodorant put on a clean shirt, placed a transfer belt around R2, stood R2 to a standing position, pulled up R2's pants and transferred R2 into the wheelchair. R2's transfer belt was removed, ULP-G removed gloves, escorted R2 to the dining room, hand sanitized and offered R2 juice and coffee. Immediately following the observation of R2's cares, ULP-G stated R2's soiled brief should have been placed in the garbage and not directly onto the floor.	0 510			

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0 510	Continued From page 5 ULP-G stated gloves should have been changed after providing R2's personal cares and before dressing R2. On July 30, 2025, at 1:30 p.m., CNS-B stated staff have been trained and re-educated on the importance of changing gloves after competing peri cares, incontinent cares and to work from "clean to dirty". CNS-B stated infection control audits were conducted regularly and CNS-B worked on the floor with ULPs to complete random audits. The licensee's undated Infection Control in the Assisted Living policy indicated hand washing should be completed after changing briefs or cleaning up a resident who had used the toilet, after touching garbage, and after the removal of gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 775 SS=G	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff.	0 775			

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0 775	Continued From page 6 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 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). Findings include: On a facility tour on July 29, 2025, from 1:15 p.m. to 3:00 p.m., with licensed assisted living director (LALD)-A, and director of maintenance (DM)-C], it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room two. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room two emergency escape and rescue clear window opening measurements are 16.5 inches wide, 40 inches in height and 660 square inches in openable area. The window was measured with DM-C, and the surveyor present. The window did not meet the minimum requirements for clear opening minimum width. It was explained to LALD-A, and DM-C, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the	0 775			

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0 775	Continued From page 7 floor to the clear opening. These deficient conditions were visually verified by DM-C, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. On the same facility tour, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: SPECIAL EXIT DOOR LOCKING ARRANGEMENTS There was one marked exit door provided with delayed egress door hardware all other marked exit doors were provided with controlled egress door locking hardware. The building was provided with a fire alarm system but not a fire sprinkler system. It was explained that buildings with controlled egress hardware installed on marked egress doors are required to be provided with fire sprinkler protection. There was not an emergency release switch installed in the nurse office or other approved location to immediately release all controlled egress and delayed egress exit doors in order for occupants to exit in the event of an emergency. There were not procedures for operation of the delayed egress and controlled egress exit doors in the employee procedures of the Fire Safety and Evacuation Plan (FSEP).	0 775			

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0 775	Continued From page 8 It was explained the procedures for operation of the special door locking arrangements installed at marked exit doors are required to be included in writing in the FSEP. EMERGENCY ESCAPE WINDOW MAINTENANCE The emergency escape and rescue windows were rotten, or crank handles were missing, and the hardware was not functioning as designed in resident sleeping room three, four, six, seven, nine, 11, 15 18. Windows did open to required minimum opening size but had to be manually pushed open. Emergency escape and rescue windows are required to open to the required minimum opening size with the normal operation of the window hardware crank in order for occupants to escape in the event of a fire or similar emergency. CARBON MONOXIDE DETECTION There was one carbon monoxide alarm observed in resident sleeping room eight. No other carbon monoxide alarms were observed in the building. It was explained that carbon monoxide alarms are required outside and with ten feet of all sleeping rooms to detect and notify occupants of the presence of carbon monoxide. CORRIDOR WALL REQUIREMENTS The corridor walls separating the resident rooms and other incidental use rooms such as offices had windows and other unprotected openings communicating with the corridor. The walls, doors	0 775			

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0 775	Continued From page 9 and other openings such as windows from rooms communicating with the egress path corridor are required to be fire resistant rated and self-closing in buildings not provided with fire sprinkler protection. It was explained the corridors are required to be fire resistant rated with self-closing doors and other openings to prevent the passage of smoke and fire in accordance with MSFC in Minnesota Rules Chapter 7511. FIRE ALARM SYSTEM TESTING AND MAINTENANCE During the tour the testing and maintenance report documentation was requested indicating the fire alarm system was tested and compliant annually as required. On Thursday July 31, 2025, at 4:55 p.m., documentation was received by email of a tag indicating the fire alarm system was tested May 2, 2024, with no testing details included. No further information was provided. FIRE RESISTANT RATED DOORS The fire-resistant rated doors of resident sleeping rooms 1 and 2 did not automatically close and latch when tested for operation. There were also several fire-resistant rated doors held open with devices that did not release to automatically close upon detection of smoke. There was not an automatic closer installed on the corridor doors leading to the shower room and laundry room. It was explained that all existing fire-resistant	0 775			

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0 775	Continued From page 10 rated doors are required to automatically close and latch. The fire-resistant rated doors are also required to automatically release to close and latch upon detection of smoke when a hold open device is used. There was a 90-minute fire-resistant rated metal door jamb with hinges on the jamb missing the fire-resistant rated door across the corridor near resident sleeping room six. It was explained that existing fire-resistant rated doors and door jambs are required to be maintained as installed at the time of construction approval. USED SMOKING MATERIALS The were used smoking materials discarded on the ground outside on the side of the building near the attached garage, behind the garage and near the front main entrance. There was a dispenser manufactured for dispensing used cigarette smoking material provided outside in the same area the cigarette butts were found on the ground. During the tour LALD-A, stated the only smokers in the facility are employees or visitors and none of the residents smoke. It was explained used cigarette smoking materials are required to be discarded in metal containers or containers manufacture for discarding used smoking materials in accordance with (MSFC) in Minnesota Rules Chapter 7511 to prevent ignition of the exterior building material by smoldering cigarette butts. OBSTRUCTIONS TO EGRESS PATH	0 775			

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0 775	Continued From page 11 There was a half door with a double keyed lock across the egress path leading to the front main exit from the dining room area. It was explained all doors or gates in the exit path are required to be openable without the use of keys, tools or special knowledge in the direction of egress travel for occupants to use in the event of a fire or similar emergency. MECHANICAL EQUIPMENT MAINTENANCE The exhaust vent pipe for the gas fired water heater in the maintenance/ mechanical room had a connection repaired with tape. It was explained that all mechanical equipment and venting is required to be maintained in accordance with MSFC in Minnesota Rules Chapter 7511 and Minnesota Mechanical and Fuel Gas Code in Minnesota Rules Chapter 1346. ELECTRICAL/ MECHANICAL EQUIPMENT STORAGE OBSTRUCTIONS There was storage in front of and obstructing access the electrical and mechanical equipment in the maintenance/ mechanical room. It was explained that electrical and mechanical equipment is required to be maintained clear of obstructions for access in the event of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

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0 810	Continued From page 12 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content	0 810			

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0 810	Continued From page 13 and provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 29, 2025, at 1:15 p.m., with licensed assisted living director (LALD)-A, and director of maintenance (DM)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP updated October 25, 2024, failed to include the following: The available 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 plan was generic and failed to include detailed procedures for employees to take in the event of a fire or similar emergency for this specific building. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar	0 810			

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0 810	Continued From page 14 emergency in writing in the FSEP. During an interview on July 29, 2025, at 1:30 p.m., LALD-A, stated the FSEP lacked detailed procedures for employees to take and written procedures for residents to take in the event of a fire or similar emergency. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by.... Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required FSEP training was provided to residents. During an interview on July 29, 2025, at 1:30 p.m., LALD-A, stated documentation was not available indicating residents were provided FSEP training as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
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	01500			

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01500	Continued From page 15 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research 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	01500			

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01500	Continued From page 16 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 all the required content for annual training for each 12 months of employment for two of three employees (clinical nurse supervisor (CNS)-B, licensed practical nurse (LPN)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include; During the entrance conference on July 29, 2025, at 10:19 a.m., licensed assisted living director (LALD)-A indicated awareness of the required contents in employee records. CNS-B CNS-B was hired on May 31, 2022, to supervise and provide care and services to residents of the facility.	01500			

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01500	Continued From page 17 On July 30, 2025, at 6:59 a.m., the surveyor observed CNS-B obtain a urine sample from R2's urinary catheter. LPN-F LPN-F was hired on January 18, 2017, and began to provided assisted living services on August 1, 2021. On July 31, 2025, at 7:40 a.m., the surveyor observed LPN-F monitor R3's blood glucose and record R3's blood glucose reading of 106 milliliters per deciliter (mg/dl) and administer 14 units of Lantus (long-acting) insulin in the back of R3's left arm. CNS-B and LPN-F's employee records lacked documentation CNS-B and LPN-F completed the following required annual training: -review of the Assisted Living Bill of Rights; -infection control; and -tuberculosis training. On July 31, 2025, at 12:23 p.m., assistant executive director (AED)-I stated the licensee had not been assigning Assisted Living Bill or Rights, infection control or tuberculosis annual training to licensed staff because they interpreted the regulation only applied to unlicensed personnel staff. The licensee's Annual Required Staff Training policy reviewed January 3, 2025, indicated all staff that perform direct care services at [name of the licensee] would complete at least eight hours of annual training for each 12 months of employment to include the following trainings: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff	01500			

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01500	Continued From page 18 responsibilities related to ensuring the exercise and protection of those rights; -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; -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; -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 -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff	01650			

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01650	Continued From page 19 who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3). 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, 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).	01650			

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01650	Continued From page 20 The findings include: During the entrance conference on July 29, 2025, at 10:19 a.m., clinical nurse manager (CNS)-B was identified responsible for the development and maintaining resident service plans. R2 R2's diagnoses included dementia, multiple sclerosis and chronic obstructive pulmonary disease (COPD). R2's Service Plan Agreement dated April 28, 2025, indicated R2 received assistance with medication management, dressing, grooming, transferring, catheter care, toileting, bathing, housekeeping and laundry services. On July 30, 2025, at 6:59 a.m., the surveyor observed CNS-B obtain a urine sample from R2's urinary catheter. R3 R3's diagnoses included dementia, diabetes type II, reduced mobility, and anxiety disorder. R3's Service Plan Agreement dated August 26, 2024, indicated R3 received assistance with medication management, dressing, compression stockings, grooming, bathing, housekeeping and laundry. On July 31, 2025, at 7:40 a.m., the surveyor observed licensed practical nurse (LPN)-F monitor R3's blood glucose and administer 14 units of Lantus insulin into the back of R3's left upper arm. R2's and R3's Service Plan Agreements lacked	01650			

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NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 303 HAT TRICK AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	Continued From page 21 the following required content: -the schedule and methods of monitoring staff providing services. On July 31, 2025, at 10:15 a.m., CNS-B stated all resident service plans used the same service plan template. CNS-B stated they thought the schedule and method of monitoring staff providing services was CNS-B reviewing residents services delivered as meeting the regulation and did not know the language content was required on the resident service plan. The licensee's undated Service Plan policy, indicated a service plan would include: -description of the services that are to be provided based on the most recent assessment and resident preferences; -fees for services to be provided; -the frequency of each service to be provided based on the most recent assessment and resident preferences; -an identification of staff or categories of staff who would be providing services; -a schedule and method of for the next planned assessment and monitoring; -a schedule and method for the next planned monitoring staff providing services; and -a contingency plan that includes actions the licensee would take if scheduled services could not be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01820 SS=D	144G.71 Subd. 13 Prescriptions	01820			

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01820	Continued From page 22 There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a client'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: R3's diagnoses included dementia, diabetes type II, reduced mobility, and anxiety disorder. R3's Service Plan Agreement dated August 26, 2024, indicated R3 received assistance with medication management. On July 31, 2025, at 7:40 a.m., the surveyor observed licensed practical nurse (LPN)-F administer 14 units of Lantus (long-acting) insulin into the back of R3's left upper arm. R3's July 2025 Medication Administration Record (MAR) indicated R3 was scheduled and received	01820			

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01820	Continued From page 23 the following medications: -aspirin 325 milligrams (mg) one tablet daily for blood thinner; -atorvastatin 40 mg one tablet daily for high cholesterol; -furosemide 20 mg one tablet daily for edema; -guaifenesin ER 600 mg twice a day for congestion; -Januvia 100 mg one tablet daily for diabetes; -Lantus Solostar insulin 14 units twice a day for diabetes; -magnesium oxide 400 mg ½ tablet daily for headaches; -metformin ER 500 mg twice a day for diabetes; -mirtazapine 30 mg one tablet twice a day for anxiety; -mupirocin 2% ointment twice a day for skin infection; -nystatin apply three times a day for skin irritation; -olanzapine 5 mg one tablet twice a day for mood agitation; -omeprazole 40 mg one capsule daily before meals for gastric reflux; -polyethylene glycol powder 17 grams (gm) daily for constipation; -vitamin D3 50 micrograms one tablet daily for supplementation; -quetiapine 50 mg one tablet daily for mental health; -donepezil hcl 10 mg one tablet at bedtime; -famotidine 40 mg one tablet at bedtime for gastric reflux; -melatonin 5 mg three tablets at bedtime for sleep; -quetiapine ER 150 mg one tablet at bedtime for mental health; and -verapamil ER 120 mg one tablet one time daily with food for headaches. On July 31, 2025, at 4:14 p.m., CNS-B reviewed	01820			

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01820	Continued From page 24 R3's prescriber orders and stated R3's prescriber orders dated June 11, 2025, and June 24, 2025, lacked a written or electronic signature by the prescriber. CNS-B and the surveyor reviewed R3's record and signed prescriber orders dated August 9, 2024, and confirmed R3's record was missing signed prescriber orders for the following medications: -Lantus Solostar 14 units of insulin twice a day; -furosemide 20 mg daily; -verapamil 120 mg -Januvia 100 mg daily: and -metformin ER 500 mg twice a day. CNS-B stated they contacted R3's pharmacy and requested electronic scripts for all of R3's medications. The licensee's undated Medication and Treatment Orders policy indicated current, written prescriber's order must be obtained for any treatment or medication administration provided to a client. The RN was responsible for assuring that current, authorized prescribed orders for medications or treatments administered by the staff were kept on file in the client's record and changes in orders were addressed in the client's service plan and communicated to the staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
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	01880			

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01880	Continued From page 25 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 ensure medications were securely stored and only authorized personnel had access to medications being stored by the licensee for one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 29, 2025, at 10:19 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided secured medication storage for the residents of the facility. CNS-B stated the licensee had one medication refrigerator in the staff office used to store resident medications requiring refrigeration. During the facility tour on July 29, 2025, at 11:36 a.m., with licensed assisted living director (LALD)-A the surveyor observed the medication refrigerator located in the staff office. The staff office was locked; however, the medication refrigerator was not secured with a lock and the office sliding glass window was opened, without a screen allowing full access to the staff office from a main hallway of the facility.	01880			

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01880	Continued From page 26 On July 30, 2025, from 7:30 a.m. to 7:50 a.m., the surveyor observed the staff office door left opened, the medication refrigerator was unlocked and the office sliding glass window was open. At 7:50 a.m., unlicensed personnel (ULP)-J walked into the staff office, put something in the staff refrigerator and closed the office door upon exit. ULP-J stated the office door locked automatically when closed and did not know why the office door was not closed all the way and left open. On July 31, 2025, at 1:07 p.m., CNS-B stated the staff office window was usually opened to get air in the office. CNS-B stated they didn't realize when the office window was open and there was no lock on the medication refrigerator, it left the medications in the refrigerator unsecured. CNS-B stated they would have maintenance put a lock on the mediation refrigerator. The surveyor and CNS-B observed the following medications being stored in the medication refrigerator: -four unopened Trulicity prefilled pens (used to treat diabetes); -one opened and one unopened bottle of latanoprost eye drops (uses to treat increased eye pressure); -three unopened Lantus SoloStar (long-acting) insulin pens; and -five unopened Humalog KwikPens (rapid-acting insulin). The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all prescription drugs would be securely locked. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

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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 date time-sensitive medications with opened and expiration dates for one of one medication cart whose medications were stored by the licensee. In addition, the licensee failed to monitor for expired medications for one of one of medication cart that provided storage for medications. Furthermore, the licensee failed to ensure medications were maintained to include an original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued for one of two residents (R3) insulins being stored by the licensee. 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:	01890			

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01890	Continued From page 28 During the entrance conference on July 29, 2025, at 10:19 a.m., clinical nurse manager (CNS)-B, stated the licensee provided medication management services to the residents at the facility. On July 29, 2025, at 1:17 p.m., the surveyor reviewed the medication cart with unlicensed personnel (ULP)-D and observed the following: -R3's opened bottle of dorzolamide eye drop lacked the date the eye drop had been opened and when the eye drop would expire; -R3's opened Lantus Solostar (long-acting) pre-filled insulin pen lacked the date the insulin had been opened and when the insulin would expire. In addition, R3's insulin pen lacked an original prescription label or identification; -R4's opened bottles of dorzolamide-timolol (used to treat increased eye pressure) and brimonidine tartrate 0.2% (used to treat glaucoma) eye drops that lacked the date the eye drops had been opened and when the eye drops would expire; -R5's opened Advair inhaler (used to treat asthma) lacked the date the inhaler had been opened and when the inhaler would expire; and -the licensee's opened stock milk of magnesium (used to treat constipation) had expired June 2025. At the time of the medication cart observation, ULP-D stated staff have been trained to date insulin pens when opened; however, was unsure about dating inhalers, and eye drops when opened. On July 30, 2025, at 12:40 p.m., CNS-B stated staff should be dating time sensitive medications when opened and if the insulin pens did not have a label from the pharmacy, the licensee applied a	01890			

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01890	Continued From page 29 sticker on the insulin pen with the resident's name and the date the insulin had been opened. The manufacturer's instructions for Dorzolamide eye drop dated January 2020, indicated to use the eye drop within 28 days after opening the eye drop bottle. The manufacturer's instructions for Lantus SoloStar insulin pen dated June 2022, indicated to throw away the Lantus SoloStar insulin pen 28 days after opened, even if the pen still had insulin left in it. The manufacturer's instructions for Dorzolamide-Timolol eye drop dated January 2022, indicated to use within 28 days after bottle first opened and to throw away the bottle four weeks after first opened even if there is solution left in the bottle. The manufacturer's instructions for brimonidine tartrate (Alphagan) eye drop dated February 2022, indicated to throw away the eye drop bottle 28 days after opening even if there was solution remaining in the bottle. The manufacturer's instructions for Advair Diskus inhaler dated January 2019, indicated to throw away the Advair inhaler one month after opening the foil pouch. 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			

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01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident record all of the required content in the disposition of medications for one of one resident (R1) upon discharge. 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	01910			

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01910	Continued From page 31 a large portion or all of the residents). The findings include: R1's diagnoses included coronary artery disease (CAD), and hypertension (high blood pressure), R1's April 2025, Medication Administration Record indicated R1 was scheduled and received the following medications: -gabapentin 100 milligrams (mg) one capsule three times a day for dementia and agitation; -olanzapine 5 mg one tablet three times a day for agitation; -aspirin 325 mg one tablet daily for heart health; -finasteride 5 mg one tablet daily for prostate hyperplasia. Do not crush; -Refresh tears 0.5% eye drops one drip in each eye daily for dry eyes; -thiamine hcl 100 mg one tablet daily for alcohol dependence; -atorvastatin 40 mg one tablet with supper for pure hyperglyceridemia; -escitalopram 5 mg one tablet at bedtime for depression; and -melatonin 3 mg two tablets every evening for insomnia. R1's prescriber orders dated April 17, 2025, included the above noted medications. R1's Discharge Summary dated April 21, 2025, indicated R1 was admitted March 4, 2025, and discharged April 21, 2025. R1's discharge summary indicated R1 received medication management and R1's medications were sent with R1 at the time of discharge. R1's Medication Disposition record dated April 21, 2025, included documentation for the disposition	01910			

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01910	Continued From page 32 of the medications noted above of the medication's name, strength, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition; however, lacked documentation of the medication prescription number, as applicable. On July 30, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was manually typing in each medication on the disposition recorded and was not aware the medication prescription numbers were required to be documented. The licensee's undated Medication Disposal policy indicated upon disposition, the licensee must document in the resident record the disposition of the medication including the medication name, strength, prescription number as applicable, quantity, to whom the medication were given, date of disposition, and names of staff and others individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the	01950			

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01950	Continued From page 33 appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and 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) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R3) receiving blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 29, 2025, at 10:19 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to the licensee's residents.	01950			

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01950	Continued From page 34 R3's diagnosis included diabetes type II. R3's Service Plan dated August 26, 2024, did not include blood glucose monitoring services. R3's Quarterly Assessment dated May 8, 2025, indicated R3 required assistance with blood glucose monitoring twice daily. R3's After Visit Summary dated June 24, 2025, included blood glucose monitoring twice a day; however, did not include parameters for staff to notify the RN or prescriber. R3's blood glucose profile dated May 1, 2025, to July 31, 2025, included documented blood glucose readings twice a day; however, lacked specific parameters of when to contact the RN. On July 31, 2025, at 7:40 a.m., the surveyor observed licensed practical nurse (LPN)-F monitor R3's blood glucose and record R3's blood glucose reading of 106 milliliters per deciliter (mg/dl) in R3's electronic medication administration record (EMAR). R3's EMAR directed to check R3's blood glucose twice a day; however, R3's record lacked specific blood glucose parameters of when to notify the RN. LPN-F stated usually residents who had blood glucose monitoring had written parameters of when to notify the RN and for some reason, R3's record did not include blood glucose parameters. On July 31, 2025, at 2:15 p.m., CNS-B stated blood glucose parameters should be indicated in the residents EMAR. CNS-B reviewed R3's record and stated there were no blood glucose parameters written in R3's record and CNS-B would add to parameters to R3's EMAR.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 303 HAT TRICK AVENUE EVELETH, MN 55734			
(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
01950	Continued From page 35 The licensee's undated Medication Management Services Provided by Unlicensed Personnel indicated an RN must specify, in writing, specific instructions for each resident and document those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R3) who received treatment 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, 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	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2025
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01970	Continued From page 36 situation has occurred only occasionally). The findings include: R3's diagnosis included diabetes type II. On July 31, 2025, at 7:40 a.m., the surveyor observed licensed practical nurse (LPN)-F monitor R3's blood glucose and record blood glucose reading of 106 milliliters per deciliter (mg/dl) in R3's. R3's Service Plan Agreement dated August 26, 2024, did not include blood glucose monitoring. R3's July 2025 Medication Administration Record (MAR) indicated R3 was scheduled and received blood glucose monitoring twice a day. R3's record included signed prescriber orders dated August 9 2024, however, did not include orders for blood glucose monitoring twice a day. R3's record included an After Visit Summary dated June 24, 2025, that included blood glucose monitoring twice a day; however, did lacked a written or electronic prescriber signature as required. On July 31, 2025, at 4:14 p.m., CNS-B reviewed R3's record and stated R3's signed prescriber orders dated August 9, 2024, did not include blood glucose monitoring. Furthermore, CNS-B stated R3's orders dated June 11, 2025, and June 24, 2025, lacked a written or electronic signature by the provider. CNS-B stated they contacted R3's pharmacy and requested electronic scripts for all of R3's treatments and medications to keep in R3's record.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER NEW JOURNEY RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 303 HAT TRICK AVENUE EVELETH, MN 55734			
(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
01970	Continued From page 37 The licensee's Medication and Treatment Orders policy dated August 1, 2024, indicated the RN was responsible for assuring current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. 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 medication administration by licensed practical nurse (LPN)-F for one of one resident (R2) whose medications were not administered as directed. In addition, LPN-F failed to ensure privacy was maintained for one of one resident (R3) during insulin administration and blood glucose (sugar) monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2025
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02320	Continued From page 38 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 29, 2025, at 10:19 a.m., clinical nurse supervisor (CNS)-B stated they were familiar with current minimum assisted living requirements. R2 R2's Service Plan dated April 28, 2025, indicated R2 required assistance with medication administration. R2's discharge summary orders dated April 23, 2025, included finasteride 5 milligrams (mg) one tablet daily and do not crush. R2's July 2025 Medication Administration Record (MAR) indicated R2's medications could be crushed. On July 31, 2025, at approximately 7:30 p.m., the surveyor observed LPN-F prepare and administer R2's scheduled morning medications. LPN-F dispensed the following medications into a clear plastic medication cup: -aspirin 325 mg one tablet (for heart health); -atorvastatin 20 mg one tablet (for high blood pressure); -divalproex 125 mg 2 capsules (for behaviors); - and -finasteride 5 mg one tablet (for prostate);	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2025
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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
02320	Continued From page 39 LPN-F crushed R2's medications except divalproex capsule. LPN-F opened the divalproex capsule and poured the medication powder into the crushed medications and mixed with applesauce and administered to R2. On July 31, 2025, at 12:05 p.m., LPN-F stated R2's MAR indicated R2 medications can be crushed so LPN-F crushed R2's medications. LPN-F stated there were no directions on R2's MAR not to crush finasteride (Proscar). LPN-F reviewed R2's Proscar medication label which indicated "Do Not Crush". LPN-F stated she missed the directions on the medication instruction label not to crush finasteride. On July 31, 2025, at 12:40 p.m., CNS-B stated staff were able to crush medications unless otherwise directed on the MAR or directions of the medication label. CNS-B verified R2's MAR did not indicate to crush finasteride and stated R2's medication instruction label directed "Do Not Crush". R3 R3 diagnosis included diabetes type II. R3's Service Plan dated August 26, 2024, indicated R3 received assistance with medications; however, did not include blood glucose monitoring. R3's After Visit Summary dated June 24, 2025, included blood glucose monitoring twice a day. R3's July 2025 MAR indicated R3 was scheduled and received blood glucose monitoring twice a day and Lantus (long-acting) SoloStar insulin 14 units twice a day.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/31/2025
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02320	Continued From page 40 On July 31, 2025, at 7:40 a.m., the surveyor observed licensed practical nurse (LPN)-F approach R3 sitting at the dining table with two other female residents present and monitor R3's blood glucose. LPN-F cleansed R3's left pointer finger with an alcohol prep pad, poked R3's finger and obtained a blood sample onto a blood glucose test strip with blood glucose reading of 106 milliliters per deciliter (mg/dl). LPN-F proceeded and injected 14 units of Lantus insulin into the back of R3's left upper arm. On July 31, 2025, at 4:14 p.m., CNS-B stated insulin administration and blood glucose monitoring should be completed in a private setting to allow privacy and should not have been conducted in the dining room especially with others present. The licensee's undated Insulin Policy directed to provide privacy for the individual. The licensee's undated Blood Glucose Testing Competency directed to provide privacy by closing the door and window covering as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2025
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02410	Continued From page 41 resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of one resident (R2) who had a urinary catheter. 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:	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2025
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02410	Continued From page 42 During the entrance conference on July 29, 2025, at 10:19 a.m., clinical nurse supervisor (CNS)-B stated they were familiar with current minimum assisted living requirements. R2's Service Plan dated April 28, 2025, indicated R2 received the Minnesota Bill of Rights for Assisted Living Residents and R2 required assistance with medications, meals, bathing, dressing, grooming, transfers, toileting, catheter cares, housekeeping and laundry. On July 30, 2025, at 6:59 a.m., the surveyor and CNS-B approached R2's room. R2's door was propped opened and R2 was observed from the hallway, uncovered lying bed in his disposable brief and R2's urinary drainage bag was attached to the right side of the bed frame, uncovered and exposed. On July 30, 2025, at 3:30 p.m., CNS-B stated R2 would kick the covers off and it was difficult to keep R2 covered up. CNS-B stated staff had just been in with R2 prior to the surveyor and CNS-B entering R2's room getting R2 ready for CNS-B to obtain a urine sample from R2's urinary catheter and that was why R2 was lying in without any pants on in a disposable brief. CNS-B stated R2's urinary drainage bag was usually in a covered case and the unlicensed personnel (ULP)s had put the cover in the laundry to be washed. CNS-B stated R2's urinary drainage bag was put in a pillowcase in the meantime until R2's drainage bag cover was laundered. The licensee's Minnesota Bill of Rights dated November 8, 2022, indicated a resident's privacy must be respected during toileting, bathing, and other activated of personal hygiene, expect as needed for resident safety or assistance.	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2025
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02410	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

New Journey
303 Hat Trick Ave
Eveleth, MN 55734
St. Louis County
Parcel:

Phone:

License Info

License: HFID 20846

Risk:
License:
Expires on:
CFPM: Jennifer L. Aysta
CFPM #: 21426; Exp: 2/10/2028

Inspection Info

Report Number: F1006251041
Inspection Type: Full - Single
Date: 7/29/2025 Time: 10:45 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 3
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 3-200B Food Characteristics:Receiving: temperature, condition

3-202.15 Priority Level: Priority 2 CFP#: 13

MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.

COMMENT: THERE WAS A BADLY DENTED CAN OF TOMATO SAUCE IN THE DRY STORAGE AREA. CAN WAS PULLED AND SET ASIDE FOR A CREDIT. MAKE SURE WHEN FOOD SHIPMENTS ARE DELIVERED THAT FOOD PACKAGING IS INSPECTED AND RETURNED IF NOT IN GOOD CONDITION.

Comply By: Complied On Site Originally Issued On: 7/29/2025

New Order: 4-200 Equipment Design and Construction

4-201.11AMN Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: ESTABLISHMENT HAS A HOMESTYLE REFRIGERATOR/FREEZER THAT IS BEING USED FOR EXTRA COLD HOLDING STORAGE. DISCUSSED THAT THIS IS NOT AN ANSI APPROVED REFRIGERATOR AND ALL REFRIGERATION NEEDS TO BE ANSI CERTIFIED. PROVIDE AN APPROVED ANSI CERTIFIED REFRIGERATOR.

Comply By: 2/1/2026 Originally Issued On: 7/29/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 Priority Level: Priority 2 CFP#: 48

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

COMMENT: ESTABLISHMENT GOT A NEW SINK AND SURFACE SANITIZER DISPENSER SYSTEM FROM ECOLAB INSTALLED IN THE KITCHEN, BUT DO NOT HAVE THE APPROPRIATE TEST STRIPS. DISCUSSED MAKING SURE TO GET THE DDBSA/LACTIC ACID TEST STRIPS FOR THE SINK AND SURFACE SANITIZER TO HELP ENSURE PROPER STRENGTHS ARE MAINTAINED AT ALL TIMES.

Comply By: 8/12/2025 Originally Issued On: 7/29/2025

New Order: 4-400 Equipment Location and Installation

4-402.11A Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

COMMENT: THE 3 COMP SINK AND FOOD PREP SINKS ARE NOT SEALED TO THE WALL. DISCUSSED MAKING SURE THESE ARE SEALED TO THE WALL.

Comply By: 9/1/2025 Originally Issued On: 7/29/2025

New Order: 4-500 Equipment Maintenance and Operation

4-502.13MN *Priority Level: Priority 3 CFP#: 39*

MN Rule 4626.0833 Cut bulk milk dispensing tubes on the diagonal, leaving no more than one inch protruding from the chilled dispensing head.

COMMENT: THE MILK DISPENSER WAS CUT STRAIGHT ACROSS AND MILK WAS VISIBLE ON THE END. TUBE WAS CUT AT AN ANGLE IMMEDIATELY.

Comply By: Complied On Site Originally Issued On: 7/29/2025

New Order: 7-100 Toxic Labeling

7-102.11 *Priority Level: Priority 2 CFP#: 28*

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

COMMENT: THERE WAS A SPRAY BOTTLE IN THE KITCHEN THAT WAS LABELED "SANI-SPRITZ" AND THE MAIN INGREDIENT WAS A QUAT BASED SANITIZER. WHEN TESTING WITH THE QUAT STRIPS IT DID NOT CHANGE AT ALL. A SINK AND SURFACE TEST STRIP WAS USED AND CHANGED COLOR. THE HEAD COOK WAS GONE DURING INSPECTION SO STAFF COULD NOT VERIFY, BUT SANI SPRAY BOTTLE WAS LIKELY REFILLED FROM THE SINK AND SURFACE DISPENSER SYSTEM. DISCUSSED GETTING NEW SPRAY BOTTLES AND GETTING THE SINK AND SURFACE LABELS SO THAT THE BOTTLE IS CORRECTLY LABELED. SANI WAS DUMPED AND STAFF WILL USE A BUCKET FOR ALL SANITIZING UNTIL LABELS ARE RECEIVED.

Comply By: Complied On Site Originally Issued On: 7/29/2025

Food & Beverage General Comment

COMMENTS:

KITCHEN IS CLEAN AND ORDERLY.

THE HOOD IS WORKING, BUT IS LOUD. DISCUSSED WITH STAFF THAT A NEW MOTOR HAS BEEN ORDERED.

DISCUSSED THE IMPORTANCE OF PROPER HAND WASHING AND NO BARE HAND CONTACT WITH ALL READY TO EAT FOODS.

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Duluth District Office inspection report number F1006251041 from 7/29/2025

Callie Harrison

Jenn Aysta
Executive Director

Callie Harrison,
Public Health Sanitarian 3
218-302-6173
callie.harrison@state.mn.us



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Page: 1

Establishment Info

New Journey
Eveleth
County/Group: St. Louis County

Inspection Info

Report Number: F1006251041
Inspection Type: Full
Date: 7/29/2025
Time: 10:45 AM

Food Temperature: Product/Item/Unit: MILK; **Temperature Process:**

Location: Dairy Dispenser at 35 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED TURKEY-TOP; **Temperature Process:**

Location: Prep Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: BUTTER- TOP; **Temperature Process:**

Location: Prep Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: PICKLES-BOTTOM; **Temperature Process:**

Location: Prep Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: STRAWBERRIES-BOTTOM; **Temperature Process:**

Location: Prep Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: PUDDING; **Temperature Process:**

Location: Upright Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: MASHED POTATOES; **Temperature Process:**

Location: Upright Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: PORK CHOPS; **Temperature Process:** Cooking

Location: at 187 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: PORK CHOPS; **Temperature Process:** Cooking

Location: at 193 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: MIXED VEGETABLES- FROM FROZEN; **Temperature Process:** Re-Heating
Location: at 165 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN; **Temperature Process:**
Location: Upright Freezer at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN; **Temperature Process:**
Location: Upright Freezer at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BUTTER; **Temperature Process:**
Location: Homestyle refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN; **Temperature Process:**
Location: Homestyle freezer at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN; **Temperature Process:**
Location: Upright Freezer at Degrees F.
Comment:
Violation Issued?: No



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Page: 1

Establishment Info

New Journey
Eveleth
County/Group: St. Louis County

Inspection Info

Report Number: F1006251041
Inspection Type: Full
Date: 7/29/2025
Time: 10:45 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Equal To 163 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Sink and Surface; **Sanitizing Process:** Dispenser

Location: Equal To 700 PPM

Comment: DDBSA*

Violation Issued?: No

Sanitizing Chemical: Product: Sink and Surface; **Sanitizing Process:** Wiping Cloth Bucket

Location: Equal To 700 PPM

Comment: DDBSA*

Violation Issued?: No

Sanitizing Chemical: Product: Sink and Surface; **Sanitizing Process:** Spray Bottle

Location: Equal To 272 PPM

Comment: DDBSA*

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1006251041			Food Establishment Inspection Report			Page <u>1</u> of <u>1</u>			
 Duluth District Office Minnesota Department of Health 11 East Superior Street, Suite 290 Duluth, MN 55802			No. of Risk Factor/Intervention/Violations		1	Date: 7/29/2025			
			No. of Repeat Risk Factor/Intervention/Violations			Time: 10:45 AM			
			Score (optional)			Dur: min			
Establishment: New Journey		Address: 303 Hat Trick Ave		City/State: Eveleth, MN		Zip: 55734		Phone:	
License/Permit #: HFID 20846		Permit Holder:		Purpose of Inspection: Full		Est. Type:		Risk Category:	
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS									
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation				
Compliance Status			COS	R	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	IN	Proper cooking time & temperatures		
2	IN	Certified Food Protection Manager			19	N/A	Proper reheating procedures for hot holding		
Employee Health					20	N/O	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	N/A	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	IN	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	IN	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	IN	Hands clean and properly washed			26	IN	Pasteurized foods used; prohibited foods not offered		
9	IN	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	IN	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	OUT	Toxic substances properly identified;stored;used	X	
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	OUT	Food in good condition, safe & unadulterated	X		Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	IN	Food separated and protected							
16	IN	Food-contact surfaces; cleaned & sanitized							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							
GOOD RETAIL PRACTICES									
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" or OUT 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				COS	R
Safe Food and Water					Proper Use of Utensils				
30	N/A	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/A	Plant food properly cooked for hot holding			47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	IN	Approved thawing methods used			48	X	Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39	X	Contamination prevented during food prep, storage, & display	X		53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
					58		Compliance with licensing and plan review		
Inspector (signature) 					Follow-up: Follow-up Date:				