



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 30, 2025

Licensee

Journeys Home Care LLC

5312 Queen Avenue North

Brooklyn Center, MN 55430

RE: Project Number(s) SL34435016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 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.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

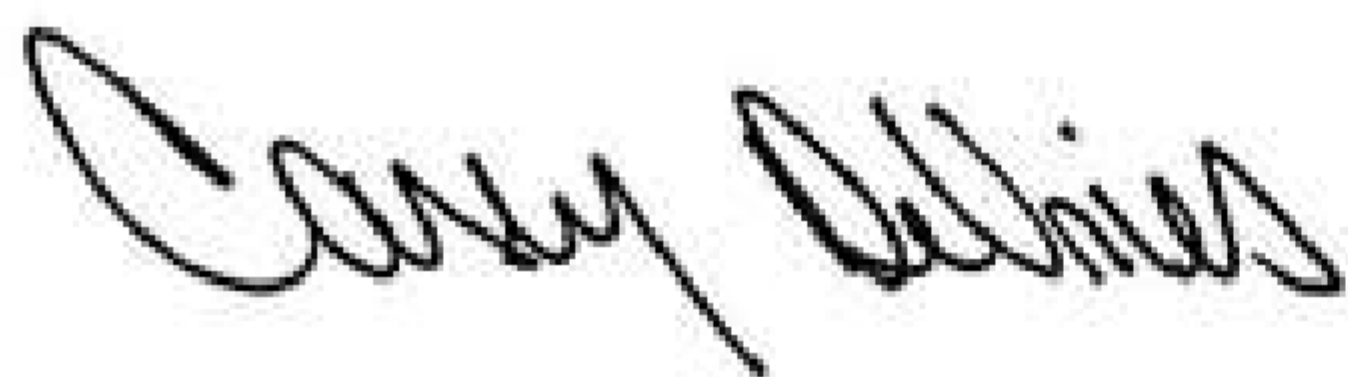
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34435	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER JOURNEYS HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5312 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34435016-0 On December 9, 2025, through December 11, 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 three residents; three residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Checklist Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted to the licensee on May 2, 2025.	0 430			

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0 430	Continued From page 2 R2's Service Plan dated October 30, 2025, indicated R2 received services for medication management, bathing assistance, grooming, incontinence care, and dressing assistance. R2's record lacked evidence the licensee's UDALSA had been provided to the resident or resident representative, to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of the services offered under the contract. On December 10, 2025, at 10:01 a.m., the surveyor observed a blank Statement of Home Care Services Comprehensive Home Care Provider form (used for home care statutes 144A, the home cares equivalent of a UDALSA) in R2's record. Licensed practical nurse (LPN)-C provided another blank Statement of Home Care Services Comprehensive Home Care Provider form and stated it was used for R2. On December 10, 2025, at 11:06 a.m., the surveyor requested for R2's signed UDALSA. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and LPN-C stated they have their residents sign the Statement of Home Care Services Comprehensive Home Care Provider form. The surveyor had to explain the difference between the Statement of Home Care Services Comprehensive Home Care Provider	0 430			

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0 430	Continued From page 3 form and a UDALSA. LALD/CNS-A stated they thought they had a copy of their UDALSA to provide. On December 10, 2025, at 11:09 a.m., LALD/CNS-A provided a blank copy of the licensee's UDALSA. LPN-C stated they did not provide a UDALSA to R2 and were currently using the Statement of Home Care Services Comprehensive Home Care Provider form for all of their residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake;	0 470			

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0 470	Continued From page 4 (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan for determining its staffing level needs. 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 the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a staffing plan to determine staffing level needs to include: -an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; -ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and -ensures that the facility can respond promptly and effectively to individual resident emergencies	0 470			

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0 470	Continued From page 5 and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On December 9, 2025, at 9:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they go off of their monthly staff schedule for staffing. The surveyor inquired if they had a staffing plan used to determine staffing levels reviewed two times annually. LALD/CNS-A stated they review their monthly staff schedule on a monthly basis. The surveyor requested the licensee's staffing plan. On December 9, 2025, at 10:37 a.m., licensed practical nurse (LPN)-C stated LALD/CNS-A was in charge of the staffing plan. The surveyor requested the licensee's staffing plan for a second time. LALD/CNS-A stated for their staff scheduling they just knew their residents needs and would staff the facility accordingly. The surveyor explained for a second time what a staffing plan was and how it was different from a schedule or policy. On December 9, 2025, at 10:45 a.m., the surveyor requested the licensee's staffing plan from LALD/CNS-A for a third time. The surveyor attempted to clarify for a third time what a staffing plan was and its requirements. LALD/CNS-A stated they only had their staff schedule and their staffing policy. The licensee's Staffing policy dated August 1, 2021, indicated: "Policy Statement: The Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs."	0 470			

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0 480	Continued From page 8 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on December 9, 2025. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550			

