Electronically Delivered

June 5, 2024

Licensee
Journeys Home Care LLC
5312 Queen Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL34435015

Dear Licensee:

On May 23, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 28, 2024, survey were corrected. 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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34435	A. BUILDING: _____ B. WING _____	R 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL34435015-2 On May 21, 2024, through May 23, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 28, 2024. At the time of the survey, there were four (4) residents that were receiving services under the assisted living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 8, 2024

Licensee
Journeys Home Care, LLC
5312 Queen Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL34435015

Dear Licensee:

On February 28, 2024, 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 November 29, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 29, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 29, 2023, found not corrected at the time of the February 28, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) - $500.00
2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on February 28, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. 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.

IMPOSITION OF FINES:

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

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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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 Renee Anderson at 651-201-5871.

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,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34435	A. BUILDING: _____ B. WING _____	R 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL34435015-1 On February 26, 2024, through February 28, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 29, 2023. At the time of the survey, there were four (4) residents; all of whom received services under the Assisted Living license. As a result of the revisit, 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 with Dementia licensed providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	{0 680}		

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{0 680}	Continued From page 1 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living facility license. 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	{0 680}		

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{0 680}	Continued From page 2 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 February 26, 2024, at 1:00 p.m., the surveyor reviewed the emergency preparedness plan and content with registered nurse (RN)-A. RN-A stated the EPP binder lacked all the required content and would need to be updated. The licensee's emergency preparedness plan dated 2021, lacked the following required content: -annual EP plan review; -development of all policies/procedures, based on assessment; and additional policies for: -handling and use of volunteers; -evacuation arrangement with other facilities (including sister facilities); -roles under a waiver declared by secretary; -EP training and testing program; -EP training program for staff (including documentation of training provided); -annual EP testing requirements. On February 26, 2024, at 1:16 p.m., RN-A stated the EPP lacked all the required content. RN-A further stated he misunderstood what all the requirements were, and therefore, did not complete all the EPP requirements. Furthermore, the licensee's undated correction order documentation from the previous survey lacked a plan of correction for EPP. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that	{0 680}		

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{0 680}	Continued From page 3 disrupts services. The policy also indicated staff would be trained on the emergency preparedness plan during orientation and annually, emergency and disaster training would be offered to all residents annually, fire drills would be conducted at the residence every other month, including at least two (2) drills for each shift for a total of six (6) fire drills annually, and the results would be documented. The policy lacked a process for handling and use of volunteers, arrangement with other facilities (including sister facilities), and roles under a wavier declared by secretary. No further information was provided.	{0 680}		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the	{0 820}		

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{0 820}	Continued From page 4 minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 28, 2024, at 11:30 a.m., survey staff toured the facility with Registered Nurse (RN)-A. During the facility tour, it was observed that the egress windows in all resident sleeping rooms had not been updated to be compliant. The survey staff observed the following: It was observed that occupied resident bedrooms #1, #2, and #3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 15 inches in height and 34 inches in width, with a total openable area of 510 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom #4 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 46 inches in height and 19 inches in width. The windows did not meet the	{0 820}		

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{0 820}	Continued From page 5 minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to RN-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. RN-A verbally confirmed the findings. On February 28, 2024, at 11:30 a.m., during the interview, RN-A stated that the licensee hired a window contractor and ordered four casement windows on December 2, 2023, but the windows had not been delivered to the facility due to manufacturing delay. RN-A also stated that he received an email confirmation from the contractor on February 27,2024, that the windows should be installed in 4 to 5 weeks. No Further information was provided.	{0 820}		
{02310} SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care,	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{02310}	Continued From page 6 medical or nursing standards for one of one resident (R2) who utilized a consumer bed rail. 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). The findings include: On November 27, 2023, at 11:20 a.m., the surveyor observed a u-shaped, silver metal portable consumer bed rail, with a black foam grip on the upper portion of the bed rail on the upper right side of R2's bed. R2 R2's diagnoses included: Parkinson's disease, cerebral palsy, psychotic mood disorder, anxiety, and brain atrophy. R2's undated service plan indicated R2 received services including assistance with activities of daily living, transferring, repositioning, and medication management. R2's record lacked documentation that licensee checked the Consumer Product Safety Commission (CPSC) website for potential recall of the P1410 model bed rail, and documentation the bedrail was used, installed, and maintained per manufacturer's guidelines. On February 26, 2024, at 10:45 a.m., RN-A stated he obtained "Essential Medical Supply,	{02310}		

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{02310}	Continued From page 7 Inc." bed rail safety information for portable bed rail model P1410R, dated June 2022, from the manufacturer website. RN-A further stated he could not locate safety information for R2's bed rail, the P1410 model. RN-A indicated licensee did not check the CPSC website for potential recall of the P1410 model bed rail. On February 26, 2024, at 10:58 a.m., the surveyor observed R2's bed rail, which RN-A had removed from R2's bed to show the surveyor. R2's bed rail had a sticker with the name "Essential Medical Supply, Inc." and the model number P1410 was printed on a label, located on the grip handle of the bed rail. On February 26, 2024, at 11:05 a.m., while in R2's bedroom, the surveyor observed RN-A place R2's bed rail on the right upper side, and under the mattress of R2's bed. R2's bed rail lacked the required security retention strap. On February 26, 2024, at 11:10 a.m., the surveyor checked the CPSC website for potential recall of P1410 model portable bed rail and noted the device had been recalled on December 22, 2021. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by	{02310}		

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{02310}	Continued From page 8 the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health's (MDH) Resources and Frequently Asked Questions (FAQ) website dated August 7, 2023, indicated the following documentation should be included in a resident's record for consumer bed rails: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bedrail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information provided.	{02310}		

Electronically Delivered

December 22, 2023

Licensee
Journeys Home Care, LLC
5312 Queen Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL34435015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for

substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. 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 the 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/HRD-Appeals-Form

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/HRD-Appeals-Form**.

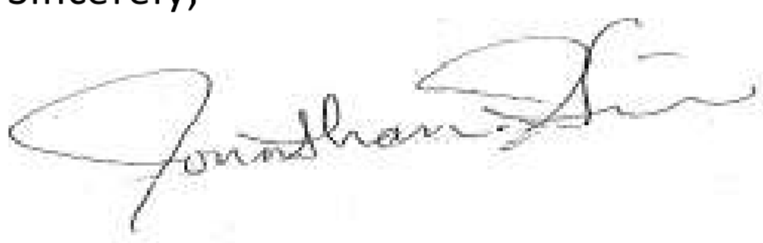
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a

reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34435	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL34435015-0 On November 27, 2023, to November 29, 2023, 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 four (4) residents, all of whom received services under the provider's Assisted Living license. On November 27, 2023, at 9:50 a.m., an immediate correction order was issued for tag number 2310. The immediacy of the order was not removed at the time of exit on November 29, 2023, at 1:55 p.m. On November 27, 2023, at 12:30 p.m., an immediate correction order was issued for tag number 0820. On November 28, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of l.	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 licensed providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 On November 28, 2023, at 11:45 a.m., an immediate correction order was issued for tag number 1290. The immediacy of the order was not removed at the time of exit on November 29, 2023, at 1:55 p.m.	0 000		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 28, 2023, 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 2 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record included the required content for two of two employees (unlicensed personnel (ULP)-C and ULP-D).	0 650		

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0 650	Continued From page 3 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: ULP-C and ULP-D started employment on May 24, 2022, and July 15, 2021, respectively, to provide direct care services to the licensee's residents. On November 28, 2023, from 8:07 a.m., through 9:00 a.m., ULP-C was observed providing assisted living services, including medication administration, and blood glucose testing for the licensee's residents. ULP-C's and ULP-D's records lacked evidence of completed training and competencies at hire to include: - maintenance of a clean and safe environment - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting - standby assistance techniques and how to perform them - medication, exercise, and treatment reminders - preparation of modified diets as ordered by a licensed health professional - awareness of commonly used health technology	0 650		

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0 650	Continued From page 4 equipment and assistive devices - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel - safe transfer techniques and ambulation - range of motioning and positioning - administering medications or treatments as required - Other RN/professionally delegated tasks (e.g., monitor vital signs, catheter, or stoma care, Broda chair, mechanical lifts). During an interview on November 28, 2023, at 12:26 p.m., registered nurse (RN)-A stated the licensee conducted the required training and competency testing with ULP-C, and ULP-D. RN-A further stated, the training and competency testing was not documented, or maintained in ULP-C and ULP-D's employee records. The licensee's Staff Competency policy dated August 1, 2021, indicated ULP would not work for Journeys Home Care until they had successfully passed the written training (at 80%) and had demonstrated a competency evaluation to include, hair care, bathing, care of teeth, gums, oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting, standby assistance techniques and how to perform them, medication, exercise, and treatment reminders, preparation of modified diets as ordered by a licensed health professional, safe transfer techniques and ambulation, range of motioning and positioning, and administering medications or treatments as required No further information was provided. TIME PERIOD FOR CORRECTION:	0 650		

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0 650	Continued From page 5 Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living facility license.	0 680		

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0 680	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 2:50 p.m., the surveyor reviewed the emergency preparedness plan and content with the registered nurse (RN)-A. RN-A stated the EPP binder lacked all the required content and would need to be updated. The licensee's emergency preparedness plan dated 2021, lacked the following required content: -development of all policies/procedures, based on assessment; and additional policies for: -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -roles under a wavier declared by secretary; -EPP training and testing program; -EPP training program for staff (including documentation of training provided); -annual EPP testing requirements. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy also indicated staff would be trained on the emergency preparedness	0 680		

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0 680	Continued From page 7 plan during orientation and annually, emergency and disaster training would be offered to all residents annually, fire drills would be conducted at the residence every other month, including at least two (2) drills for each shift for a total of six (6) fire drills annually, and the results would be documented. The policy lacked a process for handling and use of volunteers, arrangement with other facilities (including sister facilities), and roles under a wavier declared by secretary; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated portable fire	0 790		

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0 790	Continued From page 8 extinguishers as required for the facility. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and 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 November 27, 2023, at 12:00 p.m., survey staff toured the facility with registered nurse (RN)-A. During the facility tour, it was observed each of the fire extinguishers provided was 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required. It was also observed the fire extinguisher did not have an annual maintenance tag showing it had been inspected as required and lacked records to show the required monthly visual inspections were performed for portable fire extinguishers. On November 27, 2023, at 12:00 p.m., RN-A verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 9 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 12:00 p.m., survey staff toured the facility with registered nurse (RN)-A. During the facility tour, it was observed burnt used cigarettes were being disposed of without a proper disposal container on the back patio, creating a possible fire hazard.	0 800		

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0 800	Continued From page 10 On November 27, 2023, at 12:00 p.m., RN-A verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 11 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 28, 2023, at 10:00 a.m., registered nurse (RN)-A provided documenation on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The fire safety and evaucation plan (FSEP) included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility ' s building layout and environmental risks. The FSEP was a third-party consultant provided the plan, and it was not updated to meet the facility-specific layout. The FSEP plan	0 810		

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0 810	Continued From page 12 included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP did not identify specific fire protection actions for residents evident by no instructions in the FSEP. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. The plan was provided by a third-party consultant and it was not updated to meet the facility-specific layout. During the interview on November 28, 2023, at 10:00 a.m., RN-A stated the FSEP was from a third-party provider and he was unaware of the FSEP contents. RN-A verified the facility needed to update the FSEP include the facility-specific fire safety protocols. TRAINING Record review of the available documentation indicated the licensee did not provide annual training to residents who could assist in their own evacuation on the proper actions to take in the event of a fire at least once per year. Record review of the available documentation indicated employees did not receive training twice per year after initial hire	0 810		

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	34435	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	5312 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430

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0 810	Continued From page 13 During the interview on November 28, 2023, at 10:00 a.m., RN-A confirmed that the facility did not provide annual fire safety training to residents. RN-A stated the facility provided only one fire safety training in new hire orientation to employees. DRILLS Record review of the available documentation indicated the licensee did not conduct fire drills for employees twice per year per shift with at least one evacuation drill every other month. During the interview on November 28, 2023, at 10:00 a.m., RN-A confirmed there were no documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced	0 820		

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0 820	Continued From page 14 by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 12:00 p.m., survey staff toured the facility with the Registered Nurse (RN)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedrooms #1, #2, and #3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 15 inches in height and 34 inches in width, with a total openable area of 510 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom #4 on the lower level did not have windows that met the minimum size requirements for egress	0 820	This immediate correction order was identified on November 27, 2023, issued for SL34435015-0, tag identification 0820. On November 28, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 15 escape. The clear openable area of the opened windows measured 46 inches in height and 19 inches in width. The windows did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to RN-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. RN-A verbally confirmed the findings. On November 27, 2023, at 12:30 p.m., during the phone interview, survey staff explained to RN-A that an immediate correction order was issued for the above finding. RN-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced	0 970		

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0 970	Continued From page 16 by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 29, 2023, at 9:50 a.m., during R2 record review, it was noted that R2's record included a copy of the Assisted Living Contract dated January 1, 2022. R2's Assisted Living Contract included a section titled "Insurance Liability and Release" which indicated, resident agrees that Journeys Home Care would not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by negligence of Journeys Home Care or its employees or agents. Furthermore, R2's record included a Rental Agreement dated January 1, 2023, which included a "Disclaimer" under section 10, which indicated, Journeys Home Care would not insure, nor would it take responsibility for residents' personal property.	0 970		

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0 970	Continued From page 17 On November 29, 2023, at 11:00 a.m., registered nurse (RN)-A and licensed practical nurse (LPN)-B stated the Assisted Living Contract was used by licensee for all residents who received services, and the licensee's assisted living contract included a waiver of liability for health and safety or personal property of a resident. The licensee's Notifications policy dated August 1, 2021, indicated all residents of Journeys Home Care would understand their rights as recipients of home care and the services provided, and reasonable accommodations would be provided for residents with communication disabilities and whose primary language is a language other than English. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 18 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's health facility identification 34435 for two of three employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 10:30 a.m., registered nurse (RN)-A provided surveyor a current employee roster which indicated the name, title, and hire date for each employee. ULP-D ULP-D was hired on July 15, 2021, to assist with resident direct care needs. ULP-D's background study result on Department of Human Services (DHS) NETStudy 2.0 roster dated November 28, 2023, indicated "COVID-19 Study-Expired," which indicated ULP-D had a COVID-19 background study completed without fingerprints. The COVID-19 fingerprinting study	01290		

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01290	Continued From page 19 exception expired on December 31, 2022. ULP-D did not complete fingerprinting as required and was not eligible to work unsupervised. ULP-E ULP-E was hired on January 13, 2021, to assist with resident care needs. ULP-E's background study result on Department of Human Services (DHS) NETStudy 2.0 roster dated November 28, 2023, indicated "COVID-19 Study-Expired," which indicated ULP-E had a COVID-19 background study completed without fingerprints. The COVID-19 fingerprinting study exception expired on December 31, 2022. ULP-E did not complete fingerprinting as required and was not eligible to work unsupervised. During an interview on November 28, 2023, at 9:50 a.m., RN-A stated he was responsible for completing background studies on ULPs, and a cleared NETStudy 2.0 meant employees would be cleared to assist with resident care needs. RN-A stated he was not aware of the Covid-19 exception expiration. RN-A also stated he did not read the NETStudy 2.0 Final Registry Results Form in it's entirety, just the portion of the form, where it stated the Research Results were cleared for ULP-D and ULP-E. The licensee's Recruitment and Hiring policy effective date August 1, 2021, stated the director or designee is responsible for initiating the criminal background study for new employees, NetStudy 2.0 (or current version) would be used for the background check, and employees would be directed to locations established by DHS to obtain fingerprint scans. No further information was provided.	01290		

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01290	Continued From page 20 TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a),	01470		

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01470	Continued From page 21 orientation 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 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to include all required orientation content, for two of two employees (unlicensed personnel (ULP)-C, ULP-D). 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:	01470		

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01470	Continued From page 22 ULP-C and ULP-D were hired on May 24, 2022, and July 15, 2021, respectively, to provide assisted living services to the licensee's residents. On November 28, 2023, from 8:07 a.m., through 9:00 a.m., ULP-C was observed providing assisted living services, including medication administration, and blood glucose testing for the licensee's residents. ULP-C's and ULP-D's employee records lacked documented evidence the following orientation topics were completed: -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -Provider's scope of license and types of assisted living services the employee will provide; and On November 29, 2023, at 11:00 a.m., registered nurse (RN)-A stated ULP-C was assigned EduCare courses to complete upon hire, and ULP-D worked at another facility, where she completed her EduCare courses. RN-A further stated ULP-C and ULP-D's employee records lacked all the required content noted above. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through Journeys Home	01470		

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01470	Continued From page 23 Care would be prepared to provide safe, effective services to all residents through a through orientation and education program pertinent to the needs of the residents, and no employee would be able to provide direct care to residents before successfully completing the organization's orientation program. The policy indicated, Journeys Home Care would maintain proof of orientation and education in the personnel files. The policy further detailed the orientation must include: -An overview of the appropriate Assisted Living statutes and rules; -Handling of emergencies and use of emergency services; -Compliance with and reporting the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -A review of the types of assisted living services the employee will be providing and the facility's category of licensure; -The staff person's job description upon hire and whenever there is a change lo the job description that changes the nature of the job or how the job is to be performed; -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist	01470		

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01470	Continued From page 24 disclosure of services, and -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure required dementia care training for two of two employees (unlicensed personnel (ULP)-C, ULP-D). 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:	01490		

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01490	Continued From page 25 ULP-C and ULP-D were hired on May 24, 2022, and July 15, 2023, respectively, to provide assisted living services to the licensee's residents. Both employee records and training transcripts lacked documented evidence the employees had completed dementia-care related training. On November 28, 2023, from 8:07 a.m., through 9:00 a.m., ULP-C was observed providing assisted living services, including medication administration, and blood glucose testing for the licensee's residents. ULP-C's employee record and training transcripts lacked evidence the employee completed required dementia-care related training. On November 29, 2023, at 11:00 a.m., registered nurse (RN)-A stated ULP-C was assigned EduCare courses to complete upon hire, and ULP-D worked at another facility, where she completed her EduCare courses. RN-A further stated ULP-C and ULP-D lacked evidence of the required dementia care training upon hire. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through Journeys Home Care would be prepared to provide safe, effective services to all residents through a through orientation and education program pertinent to the needs of the residents. Furthermore, orientation topics would include, how to communicate with residents who have dementia, Alzheimer's Disease or related disorders, and health impacts related to untreated age-related hearing loss, such as increased incidence of dementia.	01490		

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01490	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01490		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conduct ongoing resident monitoring and reassessment, not to exceed 90	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34435	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEYS HOME CARE LLC	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
01620	Continued From page 27 calendar days from the last date of the assessment for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted May 17, 2023, and had diagnoses to include cerebral vascular accident and diabetes type 2, and alcohol-induced chronic pancreatitis. R1's record included documentation of a comprehensive nursing assessment completed May 30, 2023. No further assessment was documented in R1's medical record. R2 R2 was admitted June 30, 2020, and had diagnoses to include quadriplegia and diabetes. R2's record included documentation of an incomplete comprehensive nursing assessment dated April 20, 2020. No further assessment was documented in R2's medical record. During the entrance conference on November 27, 2023 at 10:30 a.m., registered nurse (RN)-A stated he completed vital signs and a head to toe assessment when a resident moved in. RN-A further stated RN assessments were completed	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34435	A. BUILDING: _____ B. WING _____	11/29/2023

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JOURNEYS HOME CARE LLC	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
01620	Continued From page 28 every 90-days. On November 29, 2023, at 9:50 a.m. RN-A stated R1's comprehensive assessment dated May 30, 2023, was the most recent assessment completed, and R2's incomplete comprehensive assessment dated April 20, 2020, was the most recent assessment completed. RN-A stated, no other assessments were completed for R1 and R2. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the RN would provide a reassessment visit to update the evaluation of the resident and services no more than 14-days after initiation of services, and ongoing resident reassessments would be conducted by an RN, and would not exceed 90-days from the last date of assessment. Furthermore, ongoing resident monitoring would be conducted as needed based on changes in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34435	A. BUILDING: _____ B. WING _____	11/29/2023

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02310	Continued From page 29 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 two of two residents (R1, R2) who utilized bedrails. This resulted in issuance of an immediate correction order on November 27, 2023. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 11:20 a.m., the surveyor observed bilateral half bedrails on the upper sides of R1's hospital bed in the raised position. R1 was at an outing at the time of surveyor observation. The surveyor observed portable/consumer hand bedrail on the upper right side of R2's bed. R2 was in the living room at the time of surveyor's observation. R1 R1's diagnoses included: cerebral infarction, left-sided weakness, diabetes mellitus type 2, visual loss, muscle weakness, and alcohol dependency. R1's undated service plan indicated services provides included assistance with activities of daily living, transferring, repositioning, and medication management.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34435	A. BUILDING: _____ B. WING _____	11/29/2023

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02310	Continued From page 30 R1's record lacked an assessment for the need/use of the bedrail, documentation of a risk vs. benefits discussion, documentation of the purpose/intention of the bedrail, and measurements of the bedrail's zones of entrapment. R2 R2's diagnoses included: Parkinson's disease, cerebral palsy, psychotic mood disorder, anxiety, and brain atrophy. R2's undated service plan indicated services provides included assistance with activities of daily living, transferring, repositioning, and medication management. R2's record lacked an assessment for the need/use of the bedrail, documentation of a risk vs. benefits discussion, documentation of the purpose/intention of the bedrail, and documentation the bedrail was used, installed, and maintained per manufacturer's guidelines. On November 27, 2023, at 11:45 a.m., registered nurse (RN)-A stated the bedrails had not been assessed for safety with measurements, nor was the education provided to the resident/resident representative on the risks associated with bed rail use documented. RN-A stated staff had not been trained to notify the registered nurse if bedrails were applied to a resident's bed. Licensed practical nurse (LPN)-B stated R2's family installed the portable/consumer grab bars and could not ensure that the grab bars were installed or used according to manufacturers' instructions. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included	02310		

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	34435	A. BUILDING: _____ B. WING _____	11/29/2023

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02310	Continued From page 31 the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health's (MDH) Resources and Frequently Asked Questions (FAQ) website dated August 7, 2023, indicated the following documentation should be included in a resident's record for hospital bedrails: - Purpose and intention of the bedrail; - Measurements; - The resident's bedrail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bedrail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The MDH website indicated the following documentation should be included in a resident's record for consumer bedrails: - Purpose and intention of the bedrail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bedrail; - The resident's bedrail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks);	02310		

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02310	Continued From page 32 - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bedrail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	03090		

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03090	Continued From page 33 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 finding include: On November 27, 2023, at 10:15 a.m. upon arriving at the establishment, the outside front entrance, and just inside the front entrance, were observed to lack the required posting for electronic monitoring devices to display statutory language to disclose electronic monitoring activity. On November 27, 2023, at 11:20 a.m., during a facility tour with licensed practical nurse (LPN)-B, the outside front entrance of the establishment was observed to display a green sticker, noting establishment had security cameras. Licensee's establishment lacked the required statutory language that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." On November 27, 2023, at 11:43 a.m., registered nurse (RN)-A stated licensee was not familiar with the required statutory language that needed to be displayed at front entrance of the establishment. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated, "signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided.	03090		

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03090	Continued From page 34 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *11/28/23*
Time: 13:31:04
Report: 7963231146

Food and Beverage Establishment Inspection Report

Location:
Journeys Home Care Llc
5312 Queen Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038363
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122024007
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

AFTER TESTING, DISHWASHER IS NOT REACHING THE 160 DEG F TEMPERATURE REQUIRED TO SANITIZE DISHES. USE ALTERNATE MEASURES TO SANITIZE UNTIL DISHWASHER IS REPAIRED. FACT SHEET SENT WITH REPORT.

Comply By: 11/28/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT DOES NOT CURRENTLY HAVE A CERTIFIED FOOD MANAGER. PIC RENEE ANOJI IS SCHEDULED TO TAKE A FOOD SAFETY CLASS IN DECEMBER. FACT SHEET AND APPLICATION SENT WITH REPORT.

Comply By: 11/28/23

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: LUNCH MEAT
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Type: Full
Date: *11/28/23*
Time: 13:31:04
Report: 7963231146
Journeys Home Care Llc

Food and Beverage Establishment Inspection Report

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

MET WITH RENEE ANOJE WITH JOURNEYS HOME CARE AND RHONDA MAKELA NURSE SURVEYOR WITH MDH.

DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-COLD HOLDING
-SUSCEPTIBLE POPULATION REQUIREMENTS

ESTABLISHMENT IS A RESIDENTIAL HOME DOING SAME DAY SERVICE MEAL PREPARATION.

DISHWASHER HAS A SANITIZER RINSE CYCLE BUT AFTER TESTING IS NOT REACHING 160 DEG F RINSE REQUIREMENT FOR SANITIZING DISHES.

KITCHEN HAS CERAMIC TILE FLOORS, WOOD CABINETS, LAMINATE COUNTERTOPS AND SMOOTH PAINTED CEILINGS IN THE KITCHEN AREA.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7963231146 of 11/28/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Renee Anoji
PIC

Signed:_____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963231146

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 11/28/23
Time In 13:31:04
Time Out

Journeys Home Care Llc	Address: 5312 Queen Avenue North	City/State: Brooklyn Center, MN	Zip Code: 55430	Telephone: 6122024007
License/Permit #: 0038363	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 11/28/23

Inspector (Signature) Peggy Spurley