



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 17, 2026

Licensee
Journeys
3264 Xenia Avenue North
Crystal, MN 55422

RE: Project Number(s) SL37615016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 26, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

- Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
- Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2026
NAME OF PROVIDER OR SUPPLIER JOURNEYS		STREET ADDRESS, CITY, STATE, ZIP CODE 3264 XENIA AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37615016-0 On August 24, 2026, through August 26, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 25, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
0 510 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control that included all required content. In addition, the licensee failed to implement current infection control recommendations for sharps disposal. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 510			

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0 510	Continued From page 4 the residents). The findings include: Infection Control Program On August 24, 2026, at 11:30 a.m., the surveyor requested the licensee's infection control program, and clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A provided the surveyor with the licensee's policy. The policy lacked the following required information: - evidence of leadership support; - education and training on infection prevention; - resident, family and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. On August 24, 2026, at 2:20 p.m., CNS/LALD-A stated they were aware of the requirement; however, they had not developed an infection control program as required. CNS/LALD-A also stated were busy with other responsibilities and forgot to implement the infection control program. Sharps Disposal On August 25, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications, prepare blood glucose check equipment and hand over to R1 for a self-check. After R1 had pricked for blood and checked their blood glucose, R1 disposed of the needle and lancet in the kitchen trash. On August 25, 2026, at 11:30 a.m., the surveyor asked ULP-B where they disposed of sharps and needles after use, ULP-B stated they disposed of them in the trash. ULP-B also stated that was how they were trained.	0 510			

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0 510	Continued From page 5 On August 25, 2026, at 11:45 a.m., CNS/LALD-A stated sharps and needles are disposed of in the trash. CNS/LALD-A also stated they thought the sharps container was only for long-term facilities. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those residents with documented or suspected infections with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with Occupational Safety and Health Administration (OSHA) regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control. The United States Department of Labor's OSHA - Occupational Safety and Health Standards - Bloodborne Pathogens dated May 14, 2019, indicated contaminated sharps shall be discarded immediately or as soon as feasible in containers that are: closable, puncture resistant, leakproof on sides and bottom, and labeled or color coded in accordance with standard. Also indicated the contaminated sharps containers should be easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated. The U.S. Food and Drug Administration's (FDA) Disposal of Sharps by Health Care Facilities dated April 19, 2021, indicated the FDA recommends that used needles and other sharps be immediately placed in FDA-cleared sharps disposal containers.	0 510			

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0 510	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a TB two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A, unlicensed personnel (ULP)-B).	0 660			

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0 660	Continued From page 7 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: CNS/LALD-A CNS/LALD-A started employment with the licensee on November 16, 2018, under the former comprehensive license and started to provide assisted living services on August 1, 2021. CNS/LALD-A was responsible for providing day-to-day operational oversight at the facility and providing assisted living services to residents. CNS/LALD-A's Tb record indicated CNS/LALD-A completed TB history and symptom screen on June 7, 2026, TB TST on December 31, 2020, and January 28, 2021, and a chest Xray (CXR) on November 29, 2012. CNS/LALD-A's record lacked TST results and positive TB test prior to completing a CXR. ULP-B ULP-B started employment with the licensee on June 25, 2022, to provide assisted living services. On August 25, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications, prepare blood glucose check equipment and hand over to R1 for self-check. ULP-B's record included TB history and symptom	0 660			

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0 660	Continued From page 8 screen dated February 11, 2023, and CXR dated November 8, 2022. ULP-B's record lacked a positive TB test prior to completing a CXR. On August 25, 2026, at 2:40 p.m., CNS/LALD-A stated they were not aware CXR alone was not sufficient for TB testing. CNS/LALD-A also stated they had worked in long term care previously and that a CXR was okay as long as it was negative for TB testing. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the licensee will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MOH). The precautions include the following elements: - o risk assessment - o TB screening - o staff education The Minnesota Department of Health's Assisted Living FAQs: Staff Requirements dated June 5, 2026, indicated CXR alone is not acceptable documentation. You either need documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and a CXR with provider evaluation after that date or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680	Continued From page 9	0 680			
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 observation, 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 license. This practice resulted in a level two violation (a	0 680			

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0 680	Continued From page 10 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated November 20, 2025, lacked the following required content: -EPP resident population; -policies and procedures for development of EPP; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking of staff and residents; -policies and procedures including evacuation; -policies and procedures for sheltering in place; -policies and procedures for medical documents; -policies and procedures for volunteers; -procedure for sharing information on occupancy and or needs; and -long term care family notifications. On August 24, 2026, at 12:40 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee was still working on updating their EPP to be compliant with state requirements. CNS/LALD-A also stated they thought they had included most of the missing content in their folder. However, when the surveyor asked CNS/LALD-A to find the content missing content, CNS/LALD-A stated they could not find it. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will	0 680			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 11 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. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	0 730			

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0 730	Continued From page 12 records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for one of one resident (R1) who received blood glucose monitoring.	0 730			

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0 730	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on January 25, 2023, for assisted living services. R1's Service Plan dated May 25, 2026, indicated R1 received the following services: medication administration, nurse monitoring and reassessment, bathing assistance, dressing assistance, continence care, laundry, housekeeping and linen change, food preparation, and shopping. R1's Nurse Reassessment Visit dated June 19, 2026, indicated R1 received blood glucose check once a day. On August 25, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare blood glucose monitoring supplies and handed over to R1 for a self-check. After R1 had checked their blood glucose they informed ULP-B their number was 164 milligrams per deciliter (mg/dL). The surveyor observed ULP-B record the number in R1's Diabetic Flow Sheet. R1's Diabetic Flow Sheets dated March 18, 2026, through April 3, 2026, and August 22, 2026, through August 25, 2026, indicated R1 received daily blood glucose monitoring daily. R1's diabetic	0 730			

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0 730	Continued From page 14 flow sheet lacked blood glucose monitoring documentation for the dates between April 5, 2026, through August 21, 2026. On August 25, 2026, at 2:47 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R1's blood glucose monitoring was done daily. CNS/LALD-A also stated they took the diabetic flow sheets for the missing dates to R1's provider for review but was not sure if the flow sheets remained at the provider's office or if they were misplaced in the facility office. The licensee's Treatment and Therapy Documentation policy dated August 1, 2021, indicated staff will document in the resident's clinical record. Documentation will be complete, accurate, and legible. Residents' needs will be met related to the Treatment Management Plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810			

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0 810	Continued From page 15 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 810			

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0 810	Continued From page 16 affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency	01330			

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01330	Continued From page 17 evaluations were completed for all required skill areas, prior to providing services, for one of three employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 started employment with the licensee on December 16, 2024, to provide assisted living services. ULP-C's training record lacked documentation of competency evaluations in the following areas: - standby assistance techniques and how to perform them; - safe transfer techniques and ambulation; and - range of motioning and positioning. On August 25, 2026, at 2:50 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated every employee was trained before providing services. CNS/LALD-A also stated they were not sure if the competency was not completed or just missing documentation. CNS/LALD-A stated they will peruse through the papers in the office just to make sure. However, CNS/LALD-A did not provide any more information. ULP-C was not available for interview.	01330			

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01330	Continued From page 18 The licensee's Orientation and Training - Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of the licensee delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01470 SS=F	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	01470			

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01470	Continued From page 19 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 staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), 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:	01470			

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01470	Continued From page 20 Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation prior to providing services, for three of three employees (clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A, unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS/LALD-A CNS/LALD-A started employment with the licensee on November 16, 2018, under the former comprehensive license and started to provide assisted living services on August 1, 2021. CNS/LALD-A was responsible for providing day-to-day operational oversight at the facility and providing assisted living services to residents. CNS/LALD-A's record lacked documentation of the following required orientation: - review of provider's policies and procedures; and - review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-B ULP-B started employment with the licensee on June 25, 2022, to provide assisted living services.	01470			

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01470	Continued From page 21 On August 25, 2026, at 9:15 a.m., the surveyor observed ULP-B administer medications, and prepared blood glucose equipment and hand over to R1 for self-check. ULP-B's record lacked documentation of the following required orientation: - review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-C ULP-C started employment with the licensee on December 16, 2024, to provide assisted living services. ULP-C's record lacked documentation of the following required orientation: - review of types of Assisted Living services the employee will provide and provider's scope of license. On August 25, 2026, at 2:55 p.m., CNS/LALD-A stated they were not aware employee records were missing the required orientation. CNS/LALD-A also stated they thought the employees had completed their assigned training as instructed during orientation. CNS/LALD-A further stated they had not implemented an audit system for employee records. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through the licensee will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. The policy also indicated the missing orientation training topics will be included.	01470			

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01470	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	01500			

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01500	Continued From page 23 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for three of three employees (clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A, unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01500			

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01500	Continued From page 24 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: CNS/LALD-A CNS/LALD-A started employment with the licensee on November 16, 2018, under the former comprehensive license and started to provide assisted living services on August 1, 2021. CNS/LALD-A was responsible for providing day-to-day operational oversight at the facility and providing assisted living services to residents. CNS/LALD-A's training transcript dated January 8, 2026, indicated CNS/LALD-A had completed annual training for a total of 7.25 hours in the following topics: - reporting maltreatment of vulnerable adults or minors - 1.0 hours; - Assisted Living Bill of Rights - 0.75 hours; - infection control techniques - 1.0 hours; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - 1.0 hours; - principles of person-centered planning/service delivery - 1.0 hours - dementia training - 1.5 hours; - mental illness and de-escalation - 1.0 hour. CNS/LALD-A's employee record lacked the following topic: - review of provider's policies and procedures. ULP-B ULP-B started employment with the licensee on	01500			

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01500	Continued From page 25 June 25, 2022, to provide assisted living services. ULP-B's training transcript dated January 21, 2026, indicated ULP-B had completed annual training for a total of 5.25 hours in the following topics: - reporting maltreatment of vulnerable adults or minors - 0.75 hours; - Assisted Living Bill of Rights - 0.75 hours; - infection control techniques - 1.0 hours; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - 1.0 hours; - dementia training - 0.75 hours; and - mental illness and de-escalation - 1.0 hour. ULP-B's employee record lacked the following topic: - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. ULP-C ULP-C started employment with the licensee on December 16, 2024, to provide assisted living services. ULP-C's training transcript dated January 21, 2026, indicated ULP-C had completed annual training for a total of 5.75 hours in the following topics: - reporting maltreatment of vulnerable adults or minors - 0.75 hours; - Assisted Living Bill of Rights - 0.75 hours; - infection control techniques - 1.0 hours; - effective approaches to use to problem solve when working with a resident's challenging	01500			

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01500	Continued From page 26 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - 1.0 hours; - principles of person-centered planning/service delivery - 0.5 hour - dementia training - 0.75 hours; - mental illness and de-escalation - 1.0 hour. ULP-B's employee record lacked the following topic: - review of provider's policies and procedures. On August 25, 2026, at 3:00 p.m., CNS/LALD-A stated they were not aware of the requirement to complete eight hours of annual training in specific topics. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated the following training elements MUST be included every 12 months for all staff who perform direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand-washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to solve problems when working with a resident's challenging behaviors, and how to communicate with	01500			

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01500	Continued From page 27 residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	01620			

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01620	Continued From page 28 of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted resident reassessment and monitoring at least every 90 calendar days for three of three residents (R1, R2, R3). 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	01620			

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01620	Continued From page 29 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on January 25, 2023, for assisted living services. R1's Service Plan dated May 25, 2026, indicated R1 received the following services: medication administration, nurse monitoring and reassessment, bathing assistance, dressing assistance, continence care, laundry, housekeeping and linen change, food preparation, and shopping. On August 25, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications and prepare blood glucose monitoring equipment and hand over to R1 for self-check. R1's record included Nurse Reassessment Visit (90-day) assessments completed on March 3, 2026, and June 3, 2026. R1's assessment dated June 3, 2026, was completed two days late. R2 R2 was admitted to the licensee on April 1, 2024, for assisted living services. R2's Service Plan dated June 14, 2026, indicated R2 received the following services: medication administration, nurse monitoring and reassessment, continence assistance, laundry,	01620			

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01620	Continued From page 30 housekeeping and linen change, food preparation, and transportation. R2's record included Nurse Reassessment Visit (90-day) assessments completed on March 3, 2026, and June 3, 2026. R2's assessment dated June 3, 2026, was completed two days late. R3 R3 was admitted to the licensee on August 1, 2024, for assisted living services. R3's Service Plan dated May 15, 2026, indicated R3 received the following services: medication administration, nurse monitoring and reassessment, treatments, bathing assistance, hygiene/grooming, dressing assistance, continence assistance, laundry, housekeeping and linen change, food preparation, and standby assistance for transfers. R3's record included Nurse Reassessment Visit (90-day) assessments completed on November 1, 2025, and February 1, 2026. R3's assessment dated February 1, 2026, was completed two days late. On August 25, 2026, at 2:40 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they scheduled the assessments every three calendar months (90-days) and completed the 90-day assessment on the dated the assessment was completed at the beginning of the fourth calendar month since the assessment was completed. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated registered nurse (RN) will conduct a comprehensive assessment for all residents	01620			

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01620	Continued From page 31 admitted to the licensee to determine the services required and to develop an individualized care plan for staff to implement. The assessment addresses the residents' physical, mental and cognitive needs. The policy lacked assessment schedule when assessments are conducted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650			

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01650	Continued From page 32 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, R3). 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 to the licensee on January 25, 2023, for assisted living services. R1's Service Plan dated May 25, 2026, indicated R1 received the following services: medication administration, nurse monitoring and reassessment, bathing assistance, dressing assistance, continence care, laundry, housekeeping and linen change, food preparation, and shopping. R2 R2 was admitted to the licensee on April 1, 2024, for assisted living services.	01650			

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01650	Continued From page 33 R2's Service Plan dated June 14, 2026, indicated R2 received the following services: medication administration, nurse monitoring and reassessment, continence assistance, laundry, housekeeping and linen change, food preparation, and transportation. R3 R3 was admitted to the licensee on August 1, 2024, for assisted living services. R3's Service Plan dated May 15, 2026, indicated R3 received the following services: medication administration, nurse monitoring and reassessment, treatments, bathing assistance, hygiene/grooming, dressing assistance, continence assistance, laundry, housekeeping and linen change, food preparation, and standby assistance for transfers. R1, R2, and R3's service plans lacked required content to include the following: - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On August 25, 2026, at 2:50 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were not aware the information was missing in the resident service plans. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include the following: - a description of the services to be provided and the description may be in the form of the residents care plan developed with the responsible party;	01650			

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01650	Continued From page 34 - fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; - the identification of the staff or categories of staff who would provide the services; - the schedule and methods of monitoring reviews or assessments of the resident; - the schedule and method of monitoring staff providing services; and - a contingency plan that included the following: - action to be taken if the scheduled service cannot be provided; - information and method for a resident or resident's representative to contact the facility; - names and contact information of people the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition; - the identification of and information as to who has the authority to sign for the resident in an emergency; - circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a	01730			

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01730	Continued From page 35 written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730			

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01730	Continued From page 36 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to accurately maintain an individualized medication management plan (IMMP) to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on January 25, 2023, for assisted living services. R1's Service Plan dated May 25, 2026, indicated R1 received the following services: medication administration, nurse monitoring and reassessment, bathing assistance, dressing assistance, continence care, laundry, housekeeping and linen change, food preparation, and shopping. R2 R2 was admitted to the licensee on April 1, 2024, for assisted living services. R2's Service Plan dated June 14, 2026, indicated R2 received the following services: medication administration, nurse monitoring and reassessment, continence assistance, laundry,	01730			

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01730	Continued From page 37 housekeeping and linen change, food preparation, and transportation. R3 R3 was admitted to the licensee on August 1, 2024, for assisted living services. R3's Service Plan dated May 15, 2026, indicated R3 received the following services: medication administration, nurse monitoring and reassessment, treatments, bathing assistance, hygiene/grooming, dressing assistance, continence assistance, laundry, housekeeping and linen change, food preparation, and standby assistance for transfers. R1, R2, and R3's record lacked content for IMMP to include the following: - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On August 25, 2026, at 2:50 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were unaware IMMP was missing the required content. CNS/LALD-A also stated the ULPs are trained on medication administration and when to contact RN. The licensee's Medication Management policy dated August 1, 2021, indicated the licensee will prepare and document a Medication Management Plan as part of the service plan for each resident receiving medication management services. The policy also indicated IMMP will include all the missing content above.	01730			

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01730	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation for medication administration included the signature and title of the person who administered medications for three of three residents (R1, R2, R3). 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	01760			

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01760	Continued From page 39 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: R1 R1 was admitted to the licensee on January 25, 2023, for assisted living services. R1's diagnoses included traumatic brain injury (TBI), diabetes, bipolar. R1's Service Plan dated May 25, 2026, indicated R1 received the following services medication administration, nurse monitoring and reassessment, bathing assistance, dressing assistance, continence care, laundry, housekeeping and linen change, food preparation, and shopping. R1's Medication Administration Record (MAR) dated August 2026, indicated R1 was taking the following medications: amlodipine besylate 10 milligram (mg) tablets take one tablet by mouth once daily, ferrous gluconate 324 mg take one tablet by mouth once daily on Monday, Wednesday, and Friday, folic acid 1 mg take one tablet by mouth once daily, glipizide er 5 mg take one tablet by mouth once daily, levothyroxine 137 microgram (mcg) take one tablet by mouth once daily, losartan 100-12.5 mg take one tablet by mouth once daily, meloxicam 15 mg take one tablet by mouth once daily, milk of magnesia 473 milliliter (ml) take 30 ml by mouth once daily, metformin 500 mg take two tablets by mouth twice daily, risperidone 4 mg take one tablet by mouth at bedtime, olanzapine 15 mg take one tablet by mouth at bedtime, carvedilol 12.5 mg take one tablet by mouth twice a day, acetaminophen 500 mg take two tablets by mouth	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2026
NAME OF PROVIDER OR SUPPLIER JOURNEYS			STREET ADDRESS, CITY, STATE, ZIP CODE 3264 XENIA AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 40 as needed (PRN) twice daily, diclofenac gel 1% apply 4 gram (g) topically to right ankle four times daily PRN, and furosemide 20 mg take one tablet by mouth PRN if weight gain is greater than 3 pounds (lbs.) in one day or 5 lbs. in one week. R2 R2 was admitted to the licensee on April 1, 2024, for assisted living services. R2's diagnoses included TBI, agitation, and tremors. R2's Service Plan dated June 14, 2026, indicated R2 received the following services: medication administration, nurse monitoring and reassessment, continence assistance, laundry, housekeeping and linen change, food preparation, and transportation. R2's MAR dated August 2026, indicated R2 was taking the following medications: allopurinol 30 mg take one tablet by mouth once daily, amlodipine besylate 2.5 mg tablets take one tablet by mouth once daily, atorvastatin 40 mg take one tablet by mouth once daily, daily Vite 400 mcg take one tablet by mouth once daily, Januvia 25 mg take one tablet by mouth once daily, Jardiance 25 mg take one tablet by mouth once daily, lisinopril 20 mg take one tablet by mouth once daily, levetiracetam 1000 mg take one tablet by mouth once daily, quetiapine 100 mg take one tablet by mouth once daily, gabapentin 300 mg take one capsule by mouth three times daily, and metformin 500 mg take two tablets by mouth twice daily. R3 R3 was admitted to the licensee on August 1, 2024, for assisted living services. R3's diagnoses included bipolar and Parkinson's disease.	01760			

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01760	Continued From page 41 R3's Service Plan dated May 15, 2026, indicated R3 received the following services: medication administration, nurse monitoring and reassessment, treatments, bathing assistance, hygiene/grooming, dressing assistance, continence assistance, laundry, housekeeping and linen change, food preparation, and standby assistance for transfers. R3's MAR dated August 2026, indicated R3 was taking the following medications amantadine 100 mg take one tablet by mouth once daily, calcium 600 mg/10 mcg take one tablet by mouth once daily, fiber 0.52 mg take one capsule by mouth daily, fluticasone nasal spray instill two sprays in each nostril once daily, levetiracetam 112 mcg take one tablet by mouth once daily, trazodone 150 mg take one tablet at bedtime, acetaminophen 500 mg take two tablets by mouth three time daily, and diclofenac gel 1% apply 2 gram (g) topically to each knee four times daily. R1, R2, and R3's August 2026, paper MARs indicated medications administered were documented by initials and lacked the corresponding signatures and title of the persons who completed the administration. At the bottom of MARs were spaces for the initials and signature of persons who administered medications which were blank. On August 25, 2026, at 2:20 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they expected the missing information to be part of the MAR documentation. CNS/LALD-A also stated all employees were trained in documentation requirements. CNS/LALD-A stated they had not noticed the missing information on the MARs.	01760			

Minnesota Department of Health

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01760	Continued From page 42 The licensee's Medication Management - Administration & Setup policy dated August 1, 2021, indicated assistance with medication and medication administration will be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01820			

Minnesota Department of Health

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01820	Continued From page 43 The findings include: R1 R1 was admitted to the licensee on January 25, 2023, for assisted living services. R1's diagnoses included traumatic brain injury (TBI), diabetes, bipolar. R1's Service Plan dated May 25, 2026, indicated R1 received the following services: medication administration, nurse monitoring and reassessment, bathing assistance, dressing assistance, continence care, laundry, housekeeping and linen change, food preparation, and shopping. On August 25, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare blood glucose monitoring equipment and hand over to R1 for self-check. R1's Medication Administration Record dated August 2026, indicated R1 was taking the following medications amlodipine besylate 10 milligram (mg) tablets take one tablet by mouth once daily, ferrous gluconate 324 mg take one tablet by mouth once daily on Monday, Wednesday, and Friday, folic acid 1 mg take one tablet by mouth once daily, glipizide er 5 mg take one tablet by mouth once daily, levothyroxine 137 microgram (mcg) take one tablet by mouth once daily, losartan 100-12.5 mg take one tablet by mouth once daily, meloxicam 15 mg take one tablet by mouth once daily, milk of magnesia 473 milliliter (ml) take 30 ml by mouth once daily, metformin 500 mg take two tablets by mouth twice daily, risperidone 4 mg take one tablet by mouth at bedtime, olanzapine 15 mg take one tablet by mouth at bedtime, carvedilol 12.5 mg	01820			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2026
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01820	Continued From page 44 take one tablet by mouth twice a day, acetaminophen 500 mg take two tablets by mouth as needed (PRN) twice daily, diclofenac gel 1% apply 4 gram (g) topically to right ankle four times daily PRN, and furosemide 20 mg take one tablet by mouth PRN if weight gain is greater than 3 pounds (lbs.) in one day or 5 lbs. in one week. R2 R2 was admitted to the licensee on April 1, 2024, for assisted living services. R2's diagnoses included TBI, agitation, and tremors. R2's Service Plan dated June 14, 2026, indicated R2 received the following services medication administration, nurse monitoring and reassessment, continence assistance, laundry, housekeeping and linen change, food preparation, and transportation. R2's Medication Administration Record dated August 2026, indicated R2 was taking the following medications: allopurinol 30 mg take one tablet by mouth once daily, amlodipine besylate 2.5 mg tablets take one tablet by mouth once daily, atorvastatin 40 mg take one tablet by mouth once daily, daily Vite 400 mcg take one tablet by mouth once daily, Januvia 25 mg take one tablet by mouth once daily, Jardiance 25 mg take one tablet by mouth once daily, lisinopril 20 mg take one tablet by mouth once daily, levetiracetam 1000 mg take one tablet by mouth once daily, quetiapine 100 mg take one tablet by mouth once daily, gabapentin 300 mg take one capsule by mouth three times daily, and metformin 500 mg take two tablets by mouth twice daily. R3 R3 was admitted to the licensee on August 1, 2024, for assisted living services. R3's diagnoses	01820			

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01820	Continued From page 45 included bipolar and Parkinson's disease. R3's Service Plan dated May 15, 2026, indicated R3 received the following services: medication administration, nurse monitoring and reassessment, treatments, bathing assistance, hygiene/grooming, dressing assistance, continence assistance, laundry, housekeeping and linen change, food preparation, and standby assistance for transfers. R3's Medication Administration Record dated August 2026, indicated R3 was taking the following medications: amantadine 100 mg take one tablet by mouth once daily, calcium 600 mg/10 mcg take one tablet by mouth once daily, fiber 0.52 mg take one capsule by mouth daily, fluticasone nasal spray instill two sprays in each nostril once daily, levetiracetam 112 mcg take one tablet by mouth once daily, trazodone 150 mg take one tablet at bedtime, acetaminophen 500 mg take two tablets by mouth three time daily, and diclofenac gel 1% apply 2 gram (g) topically to each knee four times daily. R1, R2, and R3's medications lacked a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications the resident was taking. On August 25, 2026, at 2:40 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had not requested for the signed orders. CNS/LALD-A also stated the pharmacy received orders from the providers before they could send them medications. The licensee's Medication Orders policy dated August 1, 2021, indicated the licensee will administer medications as prescribed by the	01820			

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01820	Continued From page 46 authorized prescriber and in accordance with all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act. The policy also indicated the licensee will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	01940			

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01940	Continued From page 47 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan (TTMP) to include all required content. In addition, the licensee failed to include blood glucose monitoring therapy in the service plan and have parameters within which to monitor blood glucose for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on January 25, 2023, for assisted living services. R1's Service Plan dated May 25, 2026, indicated R1 received the following services: medication administration, nurse monitoring and reassessment, bathing assistance, dressing assistance, continence care, laundry, housekeeping and linen change, food	01940			

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01940	Continued From page 48 preparation, and shopping. R1's Nurse Reassessment Visit dated June 19, 2026, indicated R1 received blood glucose check once a day. On August 25, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare blood glucose monitoring supplies and handed over to R1 for a self-check. After R1 had checked their blood glucose they informed ULP-B their number was 164 milligrams per deciliter (mg/dL). The surveyor observed ULP-B record the number in R1's Diabetic Flow Sheet. R1's record lacked a TTMP to include the following content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R1's service plan lacked blood glucose monitoring service. In addition, R1's record lacked the parameters to monitor blood glucose. On August 25, 2026, at 3:00 p.m., clinical nurse	01940			

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01940	Continued From page 49 supervisor/licensed assisted living director (CNS/LALD)-A stated they were unaware of the requirement for TTMP. CNS/LALD-A also stated R1's blood glucose was near normal and that they had not had any out-of-range readings to concern them. When the surveyor asked what CNS/LALD-A meant about out-of-range readings, CNS/LALD-A stated ranges below 70 milligram per deciliter (mg/dL) or above 300 mg/dL. R1's diabetic flow sheet lacked blood glucose monitoring documentation for the dates between April 5, 2026, through August 21, 2026. The licensee lacked a consistent blood glucose documentation for R1 to make informed decision regarding R1's treatment. The licensee's The licensee's Treatment & Therapy Management Plan policy dated August 1, 2021, indicated [licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatment and therapy received f. verification that all treatment and therapy were administered as prescribed g. monitoring treatment or therapy to prevent possible complications or adverse reactions.	01940			

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01940	Continued From page 50 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure that a written or electronically recorded order was obtained for one of one resident (R1) with blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 was admitted to the licensee on January 25, 2023, for assisted living services.	01970			

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01970	Continued From page 51 R1's Service Plan dated May 25, 2026, indicated R1 received the following services: medication administration, nurse monitoring and reassessment, bathing assistance, dressing assistance, continence care, laundry, housekeeping and linen change, food preparation, and shopping. R1's Nurse Reassessment Visit dated June 19, 2026, indicated R1 received blood glucose check once a day. On August 25, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare blood glucose monitoring supplies and handed over to R1 for a self-check. After R1 had checked their blood glucose they informed ULP-B their number was 164 milligrams per deciliter (mg/dL). The surveyor observed ULP-B record the number in R1's Diabetic Flow Sheet. R1's record lacked a written or electronically recorded order from an authorized prescriber for monitoring blood glucose to include the ranges within which to monitor normal blood glucose. On August 25, 2026, at 3:00 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had not requested for a signed order from R1's provider. CNS/LALD-A also stated they used after-visit summary to monitor blood glucose. CNS/LALD-A stated the after-visit summary was not in R1's record and they could not find it in their office. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated the licensee will provide all medically delegated services under an authorized prescriber's orders, when indicated.	01970			

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01970	Continued From page 52 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

JOURNEYS HOME CARE LLC
3264 XENIA AVENUE NORTH
Crystal, MN 55422
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37615

Risk:
License:
Expires on:
CFPM: Renee Ndubisi
CFPM #: 120430; Exp: 12/13/2026

Inspection Info

Report Number: F1063261234
Inspection Type: Full - Single
Date: 8/25/2026 Time: 1:30 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery:

New Order: 4-300 Equipment Numbers and Capacities

4-302.12A *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

COMMENT: No food thermometer available during inspection. Discussed rule above with operator.

Comply By: 8/25/2026 Originally Issued On: 8/25/2026

New Order: 4-600 Cleaning Equipment and Utensils

4-601.11A *Priority Level: Priority 2 CFP#: 16*

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

COMMENT: Observed buildup of grease on front of stove and control buttons. Discussed cross contamination and cleaning with operator. Operator began cleaning/sanitizing procedures during inspection.

Comply By: Complied On Site Originally Issued On: 8/25/2026

Food & Beverage General Comment

Inspection was completed with MDH Benard Nyangena as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, glove use, same day food service, food storage & temperature control, ware washing, test kits, pest control, vomit cleanup procedures, and employee illness policy.

REFRIGERATOR FOOD TEMPERATURES (DEGREES F): MILK 36

DISH MACHINE UTENSIL SURFACE TEMPERATURE (DEGREES F): >170

The facility has a residential kitchen. Food must be prepared for same day service only. The kitchen has paneled floors, smooth painted walls, popcorn ceiling, smooth countertops, and wooden cabinetry. All found to be in good condition.

Current CFPM also works at 5312 Queen Ave North Brooklyn Center, MN.

Equipment includes a two-basin sink with one compartment designated for handwashing, and ANSI residential fridge/freezer & dish machine.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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

I acknowledge receipt of the Metro District Office inspection report number F1063261234 from 8/25/2026

Joseph Ndubisi
Operator



Laura Yang,
Public Health Sanitarian 1
651-201-3581
laura.yang@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37615016-0	Date: August 25, 2026
Facility Name: JOURNEYS HOME CARE LLC	
Facility Address: 3264 Xenia Ave N, Minneapolis, Minnesota 55422	

☒ TAG IDENTIFICATION: 0810	
SCOPE/ SEVERITY: Level 2; Widespread	TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide evacuation plans that include procedures for resident movement including the identification of unique or unusual resident needs for movement or evacuation.

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide adequate record of staff training on the FSEP. Staff should be trained on the FSEP upon hire and at least twice a year thereafter.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide documentation that residents capable of assisting in their own evacuation received training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation.