DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 30, 2023

Licensee
Joyful Home Healthcare LLC
5737 Regent Avenue North
Crystal, MN 55429

RE: Project Number(s) SL35518015

Dear Licensee:

On November 22, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 18, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

November 1, 2023

Licensee
Joyful Home Healthcare LLC
5737 Regent Avenue North
Crystal, MN 55429

RE: Project Number(s) SL35518015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 18, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of

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

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

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

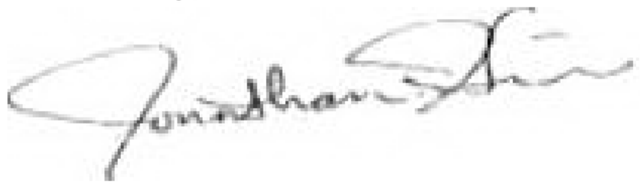
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35518	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HOME HEALTHCARE LLC	5737 REGENT AVENUE NORTH CRYSTAL, MN 55429

(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: SL35518015-0 On October 16 through October 18, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) active residents, all of whom received services under the Assisted Living license. On October 16, 2023, an immediate correction order was issued for tag identification 0820. On October 16, 2023 the immediacy lifted, noncompliance remained at H.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 1 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-B, licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 650		

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0 650	Continued From page 2 The findings include: ULP-B and LPN-D were hired July 27, 2021, and August 31, 2022, respectively, and provided direct care assistance for residents. ULP-B's record included a performance evaluation dated August 3, 2022, and signed by licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A. ULP-B and LPN-D's employee records lacked documentation of an annual performance evaluation completed within the past year. On October 17, 2023, at 2:31 p.m., LALD/CNS-A stated she normally completed the performance reviews for staff, but forgot they were due for ULP-B and LPN-D. LALD/CNS-A added there will be a more reliable reminder system going forward. The licensee's Personnel Records policy, dated March 18, 2023, indicated the employee record would include a signed job description and ocumentation of annual performance reviews identifying areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 810		

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

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0 810	Continued From page 4 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). Findings include: An interview and record review were conducted on October 18, 2023, at approximately 10:00 a.m. with Licensed Assisted Living Director/Clinical Nursing Supervisor (LALD/CNS)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Review of the available documentation and the staff training document provided by LALD/CNS-A contained the following discrepancies: - The policy states that residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility is a residential home and does not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The policy states that when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility does not have any doors that are on magnetic door holders or that are rated for smoke	0 810		

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0 810	Continued From page 5 and fire. The facility also does not have a fire alarm system that supports the use of magnetic door holders. - The policy states that the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. During interview, LALD/CNS-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Review of the provided documented drills indicated that the licensee had conducted fire drills on 9/21/23 at 12:01 p.m., 4/3/23 at 1:05 p.m. and 9/18/22 at 3 p.m. with no further drills being documented. LALD/CNS-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	0 820		

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0 820	Continued From page 6 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect more than a limited number of residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). On October 16, 2023, at approximately 12:05 p.m., survey staff toured the facility with Licensed Assisted Living Director/Clinical Nursing Supervisor (LALD/CNS)-A. During the facility tour, survey staff observed the following items: It was observed that bedroom #1 on the main level did not have windows that met the minimum size requirements for egress escape. The resident's sleeping room was occupied by the resident. The clear openable area of the opened windows measured 27 inches in width and 20 inches in height and did not meet the minimum required opening for existing sleeping rooms of 648 square inches.	0 820	This immediate correction order identified on October 16, 2023, has had the immediacy lifted as of October 16, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 7 It was observed that bedroom #2 on the main level did not have windows that met the minimum size requirements for egress escape. The resident's sleeping room was occupied by the resident. The clear openable area of the opened windows measured 15.5 inches in width and 34 inches in height and did not meet the minimum required opening for existing sleeping rooms of 648 square inches. This deficient condition was verified by LALD/CNS-A, accompanying the facility tour. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 820		
01500 SS=D	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	01500		

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01500	Continued From page 8 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for	01500		

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01500	Continued From page 9 each 12 months of employment for one of two employees licensed practical nurse (LPN)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: LPN-D was hired August 31, 2022, and provided direct care assistance for residents. On October 17, 2023, at 11:40 a.m., LPN-D was observed to assist R2 with blood glucose monitoring and medication administration. LPN-D's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -training on reporting of maltreatment of vulnerable adults under section 626.557; -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 -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.	01500		

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01500	Continued From page 10 On October 17, 2023, at 2:18 p.m., LPN-D stated she got a reminder that annual training was due, but had not completed it, and thought it was not overdue yet. On October 17, 2023, at 2:19 p.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A stated annual training would be documented on an orientation checklist. LALD/CNS-A further stated she normally got a notification in the electronic documentation program that training was due for staff, and she did not get a notification that LPN-D was overdue for training. The licensee's Staff Orientation and Education policy, dated March 18, 2023, indicated, all staff providing assisted living services would complete at least eight (8) hours of education, including required topics, for every twelve (12) months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;	01530		

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	35518	A. BUILDING: _____ B. WING _____	10/18/2023

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01530	Continued From page 11 (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of two employees licensed practical nurse (LPN)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: LPN-D was hired August 31, 2022, and provided direct care assistance for residents.	01530		

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01530	Continued From page 12 On October 17, 2023, at 11:40 a.m., LPN-D was observed to assist R2 with blood glucose monitoring and medication administration. LPN-D's employee record lacked documentation of two hours dementia care training completed within the previous 12 months. On October 17, 2023, at 2:18 p.m., LPN-D stated she got a reminder that annual training was due, but had not completed it, and thought it was not overdue yet. On October 17, 2023, at 2:19 p.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A stated she normally got a notification in the electronic documentation program that training was due for staff, and she did not get a notification that LPN-D was overdue for training. The licensee's Dementia Education policy, dated March 18, 2023, indicated, "Direct care employees will complete at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-on (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 13 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01620		

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01620	Continued From page 14 The findings include: R2's service plan, signed January 4, 2022, indicated R2 received services including assistance with medication management, grooming, bathing, meals, laundry, and housekeeping. R2's record included a comprehensive nursing assessment completed July 2, 2023, and a subsequent assessment dated as completed October 17, 2023, which was during the survey time, and greater than 90 days after the previous assessment. On October 17, 2023, at 10:14 a.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A stated the most recent assessments for R2 would be found in the electronic medical record (EMR) and none were completed on paper anymore. LALD/CNS-A added the EMR displayed a reminder when an assessment was due. On October 17, 2023, at 5:00 p.m., LALD/CNS-A stated there were two assessments done for R2 after July 2, 2023, but they had not been marked as completed in the EMR, so did not show up in the assessment history. LALD/CNS-A was unable to provide documentation to indicate the date the assessments were actually completed. The licensee's Assessment and Reassessment policy, dated March 18, 2023, indicated, "Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information was provided.	01620		

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01620	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and only authorized personnel had access for one of one resident (R2) with refrigerated medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's service plan, signed January 4, 2022, indicated R2 received services including assistance with medication management, grooming, bathing, meals, laundry, and housekeeping. R2's medication administration record for October	01880		

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01880	Continued From page 16 2023, indicated R2 received assistance with medication administration including: -lantus (insulin glargine, a long-acting insulin), 8:00 p.m. daily, October 1-16; and -Victoza (liraglutide, a diabetes medication), 9:00 a.m., daily, October 1-16. On October 16, 2023, at 4:10 p.m., the main floor kitchen refrigerator was observed to be unlocked, and contained various food items. A lower, unlocked drawer of the refrigerator contained a clear plastic tote with injectable medications: 15 injection pens of lantus and 4 injection pens of Victoza. The refrigerator and medications were accessible to all staff and residents. On October 16, 2023, at 4:11 p.m., unlicensed personnel (ULP)-B stated the refrigerator was not kept locked. On October 17, 2023, at 12:05 p.m., licensed practical nurse (LPN)-D stated the insulin was always kept in the kitchen refrigerator, and the refrigerator was never locked. On October 17, 2023, at 3:10 p.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A stated she did not normally keep the medications in the kitchen refrigerator. LALD/CNS-A further stated the medications were normally kept in the refrigerator in the locked office, but the office refrigerator had to be unplugged so repair workers could use the outlet it was plugged into. The licensee's Storage/Control of Medications policy, dated March 18, 2023, indicated, "When [licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in	01880		

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01880	Continued From page 17 substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained including the opened date for time sensitive medication storage for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01890		

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01890	Continued From page 18 R2's service plan, signed January 4, 2022, indicated R2 received services including assistance with medication management, grooming, bathing, meals, laundry, and housekeeping. R2's medication administration record for October 2023, indicated R2 received assistance with medication administration including: -lantus (insulin glargine, a long-acting insulin), 8:00 p.m. daily, October 1-16; and -Victoza (liraglutide, a diabetes medication), 9:00 a.m., daily, October 1-16. On October 17, 2023, at 11:46 a.m., R2's medication storage was observed with licensed practical nurse (LPN)-D. A tote in a locked cabinet in the kitchen contained one in-use lantus injection pen, and one in-use Victoza injection pen. Both injection pens lacked an open date to indicate when the pens were removed from the refrigerator and opened for use. -at 11:48 a.m., LPN-D stated the pens would typically be dated with a permanent marker upon opening. Registered nurse (RN)-C added it was their policy and staff were trained to date the pens when they were opened. Manufacturer directions for Victoza pen, dated July 2023, indicated once opened, the pen in use could be stored at 59ºF to 86ºF (15ºC to 30ºC), or in a refrigerator at 36ºF to 46ºF (2°C to 8°C), but must be discarded 30 days after opening. Manufacturer directions for lantus solostar pen, dated December 2020, indicated an opened pen should be kept at room temperature only (below 86°F [30°C]), and opened pens or unopened pens stored at room temperature should be discarded after 28 days.	01890		

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01890	Continued From page 19 The licensee's Storage/Control of Medications policy, dated March 18, 2023, indicated, "The licensed nurse is responsible for dating time-sensitive medications when opened." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *10/17/23*
Time: 22:00:00
Report: 8087231279

Food and Beverage Establishment Inspection Report

Location:

Joyful Home Healthcare Llc
5737 Regent Avenue North
Crystal, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038925
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124814636
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 41 Degrees Fahrenheit - Location: KENMORE FRIDGE
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: KENMORE FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 41 Degrees Fahrenheit - Location: KENMORE FRIDGE
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: KENMORE FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 16 Degrees Fahrenheit - Location: KENMORE FREEZER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR RENEE ANDERSON.

FLOORS AND CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME

THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

WHIRLPOOL BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN, ON THE RIGHT SIDE OF THE 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR RENEE ANDERSON.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087231279 of 10/17/23.

Certified Food Protection Manager: ADETOMI OMOTAYO

Certification Number: FM110608 Expires: 03/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

LOLA ULP
STAFF MEMBER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us