Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 30, 2024

Licensee
Just Like Home Senior Care
29288 Old Towne Road
Chisago City, MN 55013

RE: Project Number(s) SL28155015

Dear Licensee:

On January 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 19, 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,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

PMB

Protecting, Maintaining and Improving the Health of All Minnesotans

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November 28, 2023

Licensee
Just Like Home Senior Care
29288 Old Towne Road
Chisago City, MN 55013

RE: Project Number(s) SL28155015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 19, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

https://www.web.health.state.mn.us/form/HRD-Appeals-Form

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,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	28155	A. BUILDING: ______ B. WING ______	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	**29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

(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: SL28155015 On October 16, 2023, through October 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were three residents; all whom were receiving services under the Assisted Living license. An immediate correction order was identified on October 18, 2023, issued for SL28155015, tag identification 1290. The immediacy of 1290 was not removed at the time of exit on October 19, 2023.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 16, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630		

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0 630	Continued From page 2	0 630		

individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (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) 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:

R1 was admitted on October 27, 2022.

R1's diagnoses included hypertension, chronic respiratory failure, and chronic kidney disease.

R1's record lacked an individual abuse prevention plan which reviewed the resident's risk of abusing other vulnerable adults.

On October 17, 2023, at 1:30 p.m., director of

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0 630	Continued From page 3 nursing (DON)-A stated the IAPP for R1 does not contain the risk to abuse others and must have missed this when adding the information to the assessment. The licensee's undated Initial and ongoing Nursing Assessment of Residents policy indicated an RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive need as required: an assessment of the resident's areas of vulnerability and susceptibility to maltreatment and whether the resident poses a risk to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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0 650	Continued From page 4	0 650		

needed and training needs;
(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and
(6) documentation of the background study as required under section 144.057.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (unlicensed personnel (ULP)-B).

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-B started employment on March 25, 2021, and began providing services under the assisted living license on August 1, 2021.

On October 17, 2023, at 12:00 p.m., the surveyor observed ULP-B complete medication administration for R2.

ULP-B's employee record lacked evidence of orientation to include:
- review of provider's policies and procedures;
- reporting maltreatment of vulnerable adults;

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0 650	Continued From page 5 - handling of resident complaints, reporting of complaints, where to report; and - consumer advocacy services. On October 18, 2023, at 1:10 p.m., director of nursing (DON)-A, stated the employees records were missing parts because they are in both paper and electronic form and when the ownership had transferred to her, she had not updated the employee records to make sure they included all required content. DON-A was unable to locate the orientation checklist for ULP-B. The licensee's undated Personnel Records policy indicated the personnel record for each person will include: -record of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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Continued From page 6

(5) have a written policy and procedure regarding missing residents.
(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.
(c) The facility must meet any additional requirements adopted in rule.

This MN Requirement is not met as evidenced by:
Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents).

The findings include:

The licensee's undated emergency preparedness plan (EPP), lacked the required content:
- a developed and maintained a comprehensive EPP, reviewed/updated annually;
- a description of the population served by the licensee;

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0 680	Continued From page 7 - a process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - the development of policies/procedures to address: - procedures for tracking staff and residents; - evacuation plan; - the medical record documentation system to preserve resident information; - use of volunteers; - arrangement with other facilities; and - roles under a wavier declared by secretary. - a communication plan that included: - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or a designee; - method for sharing information from the emergency plan with residents and their families/representatives. - a developed and maintained an EP training and testing program for staff (including documentation of training provided); - evidence of conducted exercises to test the EP at least twice per year; and - a quarterly review of missing resident policy.	0 680		

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0 680	Continued From page 8 On October 17, 2023, at 3:00p.m., director of nursing (DON)-A stated the emergency preparedness plan did not contain all the required content. DON-A stated she had been focused on other aspects of the business and had not gotten around to completing the emergency preparedness plan. The licensee's undated Disaster and Emergency Plan policy, indicated the licensee must meet the following requirements: -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; - post an emergency disaster plan prominently; - provide building emergency exit diagrams to all residents; - post emergency exit diagrams on each floor; and - have a written policy and procedure regarding missing tenant residents. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 9	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in resident rooms and corridors throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 10 resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on October 16, 2023, at approximately 11:00 a.m. with director of nursing (DON)-A it was observed that smoke alarms were installed throughout the facility, but the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. Smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility. These deficient findings were visually verified by DON-A at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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Continued From page 11

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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

Findings include:

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0 810	Continued From page 12 A record review of available documentation and interview were conducted on October 17, 2023, at approximately 12:00 p.m. of documents provided by director of nursing (DON)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the facility included employee actions required in the event of a fire or similar emergency within the plan but had not updated the language to apply to this specific facility. Fire safety and evacuation plans are required to be updated to include specific employee actions required for evacuation during a fire or similar emergency for this specific facility. Record review of the available documentation indicated that the licensee did not include fire protection procedures necessary for residents in the event of a fire or similar emergency for this specific facility. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Documentation of unique and unusual needs for evacuation of each resident in the facility is required to be kept with the fire safety and evacuation plan for reference in the event of a fire or similar emergency. All deficiencies were verified by DON-A during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01290	Continued From page 13	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for five of five employees (director of nursing (DON)-A and unlicensed personnel (ULP)-B, ULP-C, ULP-D, ULP-E). This had the potential to affect all residents living within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01290		

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The findings include:

DON-A
DON-A was hired on March 25, 2021, to provide assisted living services to licensee's residents.

ULP-B
ULP-B was hired on May 2, 2023, to provide assisted living services to licensee's residents.

On October 17, 2023, at 12:00 p.m., the surveyor observed ULP-B complete medication administration for R2.

ULP-C
ULP-C was hired on May 1, 2021, to provide assisted living services to licensee's residents.

On October 18, 2023, at 8:00 a.m., the surveyor observed ULP-C complete a blood glucose reading and medication administration for R4.

ULP-D
ULP-D was hired on August 1, 2023, to provide assisted living services to licensee's residents.

ULP-E
ULP-E was hired on June 20, 2021, to provide assisted living services to licensee's residents.

DON-A, ULP-B, ULP-C, ULP-D, and ULP-E's employee records lacked documentation of a cleared background study. No one had a cleared background study to supervise anyone else.

On October 18, 2023, at 10:17 a.m., DON-A stated she was not able to verify the cleared background studies on Net Study 2.0. DON-A stated the above employee background studies

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01290	Continued From page 15 were previously ran under the facilities comprehensive license and the assisted living license in Net Study 2.0, however, the licensee could no longer access the comprehensive account as the account was disabled and the assisted living account was no longer showing any employees that had been affiliated. The licensee's undated Background Checks policy indicated all employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. The licensee's undated Personnel Records policy indicated the personnel records for each person will include documentation of a completed background study. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
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	01470		

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01470	Continued From page 16 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), 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	01470		

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01470	Continued From page 17 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-B ULP-B started employment on March 25, 2021, and began providing services under the assisted living license on August 1, 2021. On October 17, 2023, at 12:00 p.m., the surveyor observed ULP-B complete medication administration for R2. ULP-B's employee record lacked the following required orientation content to be completed before providing assisted living services to residents: - principles of person-centered planning/service delivery. ULP-D	01470		

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ULP-D started employment on August 1, 2023.

ULP-D's employee record lacked the following required orientation content to be completed before providing assisted living services to residents:
- overview of Assisted Living statutes;
- assisted living bill of rights;
- consumer advocacy services; and
- principles of person-centered planning/service delivery.

On October 18, 2023, at 1:10 p.m., director of nursing (DON)-A, stated all the employee records were missing the person-centered care orientation because this training had not been implemented. DON-A confirmed ULP-D had not completed all the required orientation topics as they had not been assigned in the computer learning system and was still using the comprehensive home care checklist for documenting the employee orientation.

The licensee's undated Orientation and Training policy indicated all staff providing and supervising direct care services must complete an orientation to assisted living facility licensing requirement and regulations before providing assisted living services to residents.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

01500 SS=F — 144G.63 Subd. 5 Required annual training — 01500

(a) All staff that perform direct services must complete at least eight hours of annual training

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01500	Continued From page 19 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 (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	01500		

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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 annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-B) reviewed.

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:

ULP-B started employment on March 25, 2021, and began providing services under the assisted living license on August 1, 2021.

On October 17, 2023, at 12:00 p.m., the surveyor

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observed ULP-B complete medication administration for R2.

ULP-B's record lacked documentation of eight hours of annual training completed within the previous 12 months in the following areas:
- Reporting maltreatment of vulnerable adults;
- Assisted Living bill of rights;
- Infection control techniques
- Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;
- Review of provider's policies and procedures; and
- Principles of person-centered planning/service delivery.

On October 18, 2023, at 9:35 a.m., director of nursing (DON)-A stated she has no evidence of the 8 hours of required annual training and this would be the case for all the employees. DON-A stated she had relied on the training software program to assign the required classes to the employees annually and did not realize the program was not working.

The licensee's undated Orientation and Training policy indicated 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.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one

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01500	Continued From page 22 (21) days	01500		
01530 SS=F	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; (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 all direct care staff received at least eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees	01530		

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as required for two of two employees (unlicensed personnel (ULP)-B, ULP-D).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:

ULP-B
ULP-B started employment on March 25, 2021, and began providing services under the assisted living license on August 1, 2021.

On October 17, 2023, at 12:00 p.m., the surveyor observed ULP-B complete medication administration for R2.

ULP-B's employee record indicated ULP-B completed 5.25 hours of dementia care training, thus did not contain documentation ULP-B completed the initial eight hours of training required related to dementia care, within 160 working hours of ULP-B's employment start date.

ULP-D
ULP-D started employment on August 1, 2023.

ULP-D's employee record indicated ULP-D completed hours of 0 hours of dementia care training, thus did not contain documentation ULP-D completed the initial eight hours of training required related to dementia care, within 160 working hours of ULP-D's employment start date.

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01530	Continued From page 24 On October 18, 2023, at 1:10 p.m., director of nursing (DON)-A, stated the employees records were missing the required 8 hours of initial dementia care training documentation and both employees had worked over 160 hours. The licensee's undated Personnel Records policy indicated the personnel record for each person would include record of all required training for unlicensed personnel and competency determinations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620		

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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 a registered nurse (RN) conducted ongoing 14-day resident reassessment for one of two residents (R1), and failed to conduct ongoing nursing assessments not to exceed 90 calendar days for two of two residents (R1, R2).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1
R1 was admitted to the licensee on October 27, 2022.

R1's diagnoses included hypertension, chronic respiratory failure, and chronic kidney disease.

R1's service plan dated October 17, 2023, indicated R1 received services to include medication management, bathing assistance, dressing assistance, oxygen delivery, toileting, meal assistance, housekeeping, and laundry.

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R1's record included an admission assessment dated October 27, 2022, however, R1's 14-day assessment dated December 5, 2022, was 26 days overdue. R1's 90-day assessment was due on or by January 25, 2023, and was 16 days overdue.

R2
R2 was admitted for services under the comprehensive home care license on March 25, 2021, and began receiving assisted living services on August 1, 2021.

R2's diagnoses included diabetes mellitus type II, hypertension, chronic kidney disease.

R2's service plan dated October 17, 2023, indicated R2 received services to include medication management, blood glucose checks, bathing assistance, dressing assistance, housekeeping, and laundry.

On October 17, 2023, at 12:00 p.m., the surveyor observed ULP-B complete medication administration for R2.

R2's record included a 90-day nursing assessment dated February 9, 2023, and July 1, 2023. The assessment completed on July 1, 2023, was 53 days overdue.

On October 18, 2023, at 2:34 p.m., director of nursing (DON)-A confirmed ongoing reassessments were not in compliance and had been completed late. DON-A stated this would be the case for all the residents. DON-A stated she had hired a nurse to complete the assessments and did not realize they were not being completed on time and that she had also completed some of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: ______ B. WING ______	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 27 the resident reassessments late. The licensee's undated Initial and On-Going Nursing Assessment of Residents policy indicated a RN will complete the following comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required. -Pre-Admission Assessment -14-day assessment: completed up to 14-days after start of services -Ongoing assessment: completed periodically but no less than every 90-days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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	28155	A. BUILDING: ______ B. WING ______	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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01640	Continued From page 28	01640		

including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to complete a service plan within 14 days of admission for two of two residents (R1, R2).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1
R1 was admitted to the licensee on October 27, 2022.

R1's diagnoses included hypertension, chronic respiratory failure, and chronic kidney disease.

R1's medical record lacked evidence of a signed service plan prior to the date of survey entrance.

R1's service plan, printed after the initiation of the survey, on October 17, 2023, indicated R1 received services to include medication management, bathing assistance, dressing assistance, oxygen delivery, toileting, meal assistance, housekeeping, and laundry. R1 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: ____ B. WING ____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	**29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

(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
01640	Continued From page 29	01640		

signed the service plan with the admission date of October 27, 2022.

R2
R2 was admitted for services under the comprehensive home care license on March 25, 2021, and began receiving assisted living services on August 1, 2021.

R2's diagnoses included diabetes mellitus type II, hypertension, and chronic kidney disease.

On October 17, 2023, at 12:00 p.m., the surveyor observed ULP-B complete medication administration for R2.

R2's medical record lacked evidence of a signed service plan prior to the date of survey entrance.

R2's service plan, printed after the initiation of the survey, dated October 17, 2023, indicated R2 received services to include medication management, blood glucose checks, bathing assistance, dressing assistance, housekeeping, and laundry. R2 had signed the service plan with the admission date of March 25, 2021.

On October 17, 2023, at 3:20 p.m., director of nursing (DON)-A confirmed the residents did not have signed service agreements prior to today and this would be the case for all the residents. DON-A stated she was switching the records from paper to electronic and forgot to print them out but had verbally gone over the service plan with the residents.

The licensee's undated Service Plan policy indicated no later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: ______ B. WING ______	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	**29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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01640	Continued From page 30 plan. The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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 discard expired medication 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). The findings include: R2 was admitted for services under the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28155	A. BUILDING: ______ B. WING ______	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME SENIOR CARE	**29288 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

(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
01890	Continued From page 31 comprehensive home care license on March 25, 2021, and began receiving assisted living services on August 1, 2021. R2's diagnoses included diabetes mellitus type II, hypertension, and chronic kidney disease. R2's service plan dated October 17, 2023, indicated R2 received services to include medication management, blood glucose checks, bathing assistance, dressing assistance, housekeeping, and laundry. On October 17, 2023, at 12:00 p.m., the surveyor observed ULP-B complete medication administration for R2. On October 17, 2023, at 2:00 p.m., the surveyor observed R2's medication cabinet and observed the following expired medications: - amlodipine 10 milligrams (mg) with an expiration date of April 22, 2023; - metoprolol 50 mg with an expiration date of April 22, 2023; and - gabapentin 300 mg with an expiration date of April 22, 2023. On October 17, 2023, at 2:30 p.m., director of nursing (DON)-A confirmed R2's medications were expired. DON-A stated she had put medication destruction off for a while and did not realize there were medications that needed to be destroyed. The licensee's undated Storage of Medications policy indicated medications will be handled and stored per acceptable standards. No further information was provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/16/23*
Time: 13:15:00
Report: 1025231230

Food and Beverage Establishment Inspection Report

Location:
Just Like Home Senior Care
29288 Old Town Road
Chisago City, MN55013
Chisago County, 13

Establishment Info:
ID #: 0038906
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7637420373
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities
4-302.14 ***** Priority 2 *****
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
Provide a test kit to test sanitizing solutions (e.g. chlorine bleach strips to 50-100 PPM)
Comply By: 10/18/23

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
Employ a CFPM for the establishment (search "MDH CFPM" for information)
Comply By: 10/16/23

4-300 Equipment Numbers and Capacities
4-301.12C
MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.
Provide a 3 compartment sink, or substitute sink basins or alternate basins for warewashing. Reported a dishwasher to be purchased; see comments (look for NSF/ANSI 184)
Comply By: 10/16/23

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator (main kitchen)
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Pork, pkg
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator (second kitchen)
Violation Issued: No

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

TMD available
Discussed 4626.0506 G
For information on, wash, rinse, sanitize procedure, please search "MDH Sanitizing"
Face sheet for cook temperatures printed in color and put on refrigerator during inspection

FINISHES
Laminate countertops, wood cabinets, laminate flooring, hollow enclosed base cabinets
Facility has finishes with are not smooth, durable, easily cleanable, or are absorbent.

SINK USAGE
Facility has a two basin sink (and a separate sink in a separate kitchen which is mostly unused)
Facility does not have a dedicated food preparation sink
Facility does not have a 3 compartment sink

DISHWASHING
Dishwasher is not marked with label/data plate indicating it reaches an internal contact temperature necessarily for sanitizing (NSF/ANSI 184: Residential Dishwasher). Discussed using the dishwasher to wash and rinse dishes and utensils, and providing a bus tub/other basin for a chemical sanitizing (e.g. chlorine bleach 50-100 PPM or other chemical per label for sanitizing "food contact surfaces", submerge utensils for 1-2 minutes and air dry). Sanitize clean dishes and utensils in a container large enough to submerge the largest utensil. Provide an appropriate sanitizer for "food-contact surfaces" (label will include it as a heading) and an appropriate test kit.

4626.0680 Alternative manual warewashing equipment that meets the requirements in parts 4626.0875 and 4626.0880 may be used when there are special cleaning needs or constraints and its use is approved by the regulatory authority. Alternative manual warewashing equipment may include:
[…] (5) receptacles that substitute for the compartments of a multicompartment sink.
https://www.nsf.org/consumer-resources/articles/dishwasher-certification

COUNTERTOPS AND FOOD CONTACT SURFACES
Facility has laminate countertops
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher).
Plastic cutting board provided
Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean but without the use of chemicals which may damage the finish. Do not use wood as a food contact surface.

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding

Food and Beverage Establishment Inspection Report

establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

GENERAL COMMENTS
Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness
Food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator (meats on bottom, produce on top), separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest control
Highly susceptible populations - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
Provide a food thermometer with a thin probe (a digital thermometer with the thin tip)
Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days)
Chemical label, use, and storage
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

ADDITIONAL INFORMATION

"MDH Highly Susceptible Population"
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf
"MDH TCS Foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/tcsfoodfs.pdf
"MDH Sanitizing"
https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf

Food and Beverage Establishment Inspection Report

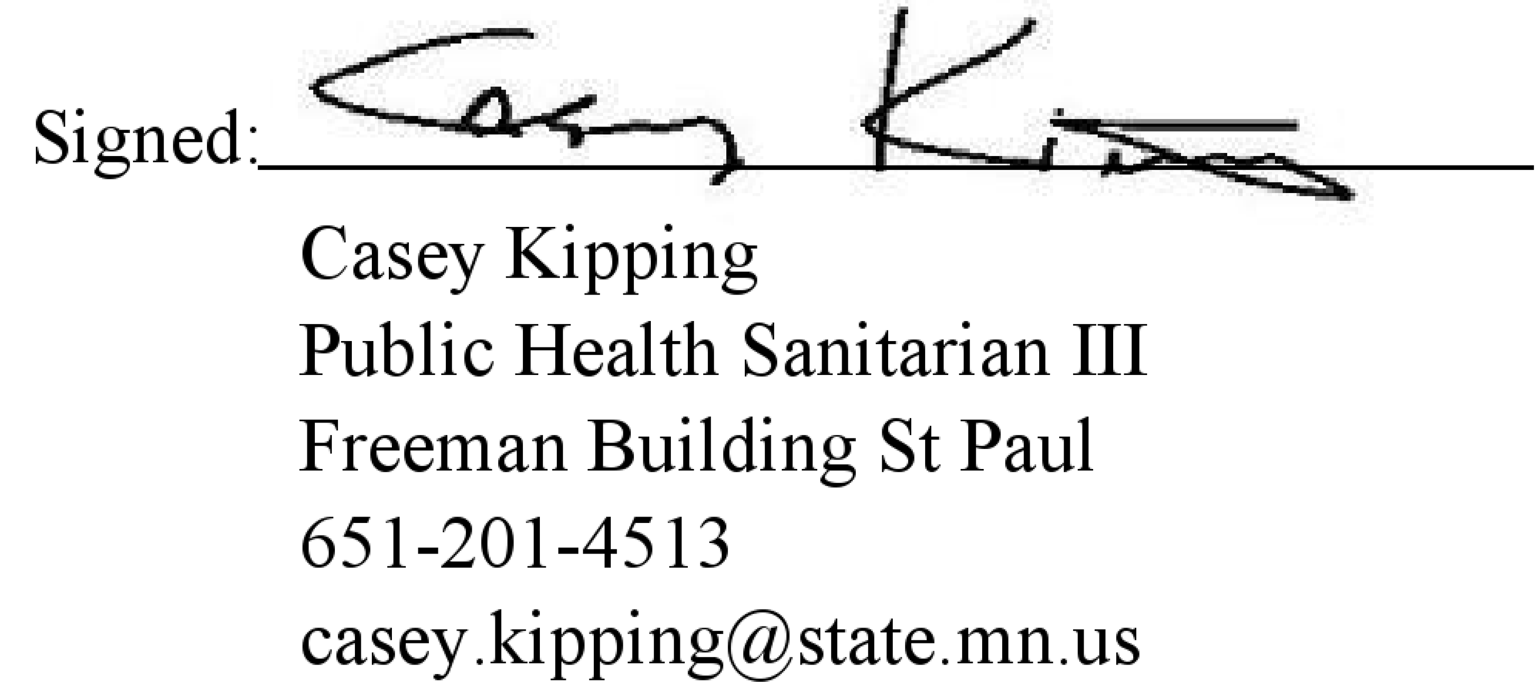
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025231230 of 10/16/23.

Certified Food Protection Manager: TBD

Certification Number: ______________ Expires: / /

Signed:
Amanda

Signed: 

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231230

Food Establishment Inspection Report

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date 10/16/23
No. of Repeat RF/PHI Categories Out	0	Time In 13:15:00
Legal Authority MN Rules Chapter 4626		Time Out

Just Like Home Senior Care	Address 29288 Old Town Road	City/State Chisago City, MN	Zip Code 55013	Telephone 7637420373
License/Permit # 0038906	Permit Holder	Purpose of Inspection Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

#	Compliance Status (circled)	Item	COS	R
	Surveillance: Supervision			
1	IN	PIC knowledgeable; duties & oversight		
2	OUT	Certified food protection manager, duties		
	Employee Health			
3	IN	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN	Proper use of reporting, restriction & exclusion		
5	IN	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN	Proper eating, tasting, drinking, or tobacco use		
7	IN	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean & properly washed		
9	IN	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food received at proper temperature		
13	IN	Food in good condition, safe, & unadulterated		
14	N/A	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN	Food separated and protected		
16	IN	Food contact surfaces: cleaned & sanitized		
17	IN	Proper disposition of returned, previously served, reconditioned, & unsafe food		
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperature		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time & temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as a public health control: procedures & records		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	N/A	Food additives: approved & properly used		
28	IN	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

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

#	Status	Item	COS	R
		Safe Food and Water		
30	N/A (circled)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	N/A (circled)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O (circled)	Plant food properly cooked for hot holding		
35	N/O (circled)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) [signature] **Date:** 10/16/23

Inspector (Signature) [signature]