Electronically Delivered

September 12, 2024

Licensee
Home Joy Home Care, Inc.
7632 83rd Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL34049015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 9, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34049	A. BUILDING: _____ B. WING _____	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME JOY HOME CARE, INC	7632 83RD AVENUE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, 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: SL#34049015 On August 5, 2024, through August 9, 2024, 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 4 residents; 4 receiving services under the Assisted Living license.	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 Assisted Living facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 6, 2024, 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		
0 650 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	0 650		

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0 650	Continued From page 2 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 contained the required content to include an annual performance evaluation for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 650		

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0 650	Continued From page 3 The findings include: ULP-C had a hire date of May 11, 2021. ULP-C's employee record lacked documentation of an annual performance review. On August 5, 2024, at 12:50 p.m., clinical nurse supervisor (CNS)-B acknowledged ULP-C's employee file lacked documentation of any annual performance reviews and stated wasn't sure if any annual performance reviews were completed for ULP-C. The licensee's Performance Evaluations policy undated, indicated a performance evaluation would be completed annually for each employee and the performance review would be maintained in each employee's record. No further information 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;	0 680		

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0 680	Continued From page 4 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 5, 2024, at approximately 2:30 p.m., clinical nurse supervisor (CNS)-B provided an email attachment that was stored on the CNS-B's office computer and stated the contents were the licensee's EPP.	0 680		

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0 680	Continued From page 5 The licensee's EPP undated, lacked an individualized plan to include all the required content below: - facility's Hazard Vulnerability Analysis (HVA); -missing annual review; -missing resident quarterly review; -description of the population served by licensee; -process for EP cooperation with state and local EP officials/organizations; -development of all policies/procedures (P/P) based on HVA assessment; -development of a communication plan; and -EP training and testing program. On August 5, 2024, at approximately 3:00 p.m., CNS-B acknowledged the licensee's EPP lacked the above listed required content. CNS-B stated the licensee's EPP was a work in progress and was not aware of all the requirements of Appendix Z. The licensee's Emergency Management policy undated, indicated the licensee would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 6 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 document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety	0 810		

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0 810	Continued From page 7 and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 7, 2024, at 3:48 p.m., survey staff received an email from the clinical nurse supervisor (CNS)-B with eight PDF attachments of the home's fire safety and evacuation plan, training documentation and related policies, and evacuation drill records for review. On August 8, 2024, at approximately 10:00 a.m., a document and record review and teleconference interview with the CNS-B indicated the following: -Document review indicated the home ' s basement evacuation diagram did not include room numbers for each resident's bedroom. Evacuation plans must include the location and resident sleeping room numbers. -Document review indicated the licensee's fire safety and evacuation plan failed to include site-specific employee actions to take in the event of a fire or similar emergency relative to the home's building layout and conditions, and resident movements during a fire or similar emergency. The fire safety plan documents provided and available for review were training	0 810		

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0 810	Continued From page 8 materials labeled as "fire and electrical safety, 7/23" and "operating room fire safety". During the interview, the CNS-B stated that the licensed assisted living director (LALD)-A was on vacation and the CNS-B provided available documents. -Document review indicated the licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During the interview, the CNS-B verified the plan lacked these provisions and stated that the LALD-A was on vacation and the CNS-B sent the information that was available. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the CNS-B verified that the fire safety and evacuation plan did not include these provisions. -Record review of available documentation indicated that the licensee did not provide the minimum required employee training on the fire safety and evacuation plan twice per year after the initial hire training. During an interview, the CNS-B confirmed one training record was available, July 2023. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year. The CNS-B was unable to provide documentation showing any training offered to residents on the fire safety and	0 810		

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0 810	Continued From page 9 evacuation plan. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills consisting of twice per year, per shift with at least one evacuation drill every other month. Record review indicated that a total of one evacuation drill, dated May 12, 2024, at 11:00 a.m., was conducted to date for the year 2024 and no records or logs of evacuation drills were provided or available for calendar years 2023 and 2022. During the interview, the CNS-B stated no other records were available to the CNS-B and verified the licensee did not meet the minimum required evacuation drills. The above deficient findings were verified by the CNS-B during the interview. The CNS-B acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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;	01500		

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01500	Continued From page 10 (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 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	01500		

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01500	Continued From page 11 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: ULP-C had a hire date of May 11, 2021. ULP-C's training record lacked evidence of the eight hours annual training requirement to include all the required content below: -Review of provider's policies and procedures; and -Principles of person-centered planning/service delivery. On August 5, 2024, at 12:55 p.m., clinical nurse supervisor (CNS)-B stated ULP-C did not complete the required annual training and was unaware of all the required annual training content. CNS-B also stated would ensure all the	01500		

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01500	Continued From page 12 required annual training for employees would be completed. The licensee's Annual Training Requirements policy undated, indicated the required trainings would be completed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34049	A. BUILDING: _____ B. WING _____	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME JOY HOME CARE, INC	7632 83RD AVENUE NORTH BROOKLYN PARK, MN 55445

(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 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 29, 2021. R1's 90 Day Assisted Living Reassessment records dated June 30, 2024, March 30, 2024, and December 30, 2023, were one-page documents identified by clinical nurse supervisor (CNS)-B as R1's last three consecutive 90-day RN assessments completed by CNS-B. The assessments lacked a full physical and cognitive assessment as required on the uniform assessment tool. On August 5, 2024, at 3:00 p.m., CNS-B stated the licensee performed a comprehensive assessment once a year that included all the elements of the uniform assessment tool, then used the one-page RN assessment for all other	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34049	A. BUILDING: _____ B. WING _____	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME JOY HOME CARE, INC	7632 83RD AVENUE NORTH BROOKLYN PARK, MN 55445

(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 14 assessments during the year and was not aware of the Uniform Assessment Tool requirement for all 90-day assessments. The licensee's Nursing Assessment and Reassessment of Residents policy undated, indicated a nursing comprehensive assessment would be conducted at least every 90 days. Minnesota Administrative Rule 4659.0140 dated August 11, 2021, indicated nursing assessments and reassessments must contain the required content of Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01880 SS=D	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 refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34049	A. BUILDING: _____ B. WING _____	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME JOY HOME CARE, INC	7632 83RD AVENUE NORTH BROOKLYN PARK, MN 55445

(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
01880	Continued From page 15 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: On August 5, 2024, at approximately 10:45 a.m., during a tour of the facility, the surveyor observed an unlocked medication refrigerator inside clinical nurse supervisor (CNS)-B's office that lacked a thermometer and temperature log. Twelve (12) prefilled syringes of Enbrel SRCLK INJ 50 milligrams (mg)/milliliters (ml) (inject 50mg subcutaneously once a week for reducing symptoms with ankylosing spondylitis of spine) was observed stored in the refrigerator. Manufacturer storage directions for Enbrel SRCLK INJ 50 mg/ml dated July 2024, indicated protect from light, store in the refrigerator at 36°F [degrees Fahrenheit] to 46°F, and do not freeze. On August 5, 2024, at 2:15 p.m., CNS-B acknowledged the licensee's medication refrigerator that stored R1's medications lacked temperature tracking and was unaware of the medication temperature tracking per manufacturer's instructions. The licensee's Individualized Medication Management Plan and Record policy undated, indicated medication stored would be consistent with manufacturer's recommendations. No further information was provided.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34049	A. BUILDING: _____ B. WING _____	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 16 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2024, at 9:50 a.m., upon entering the facility, the surveyor observed one entrance accessible by visitors to the facility and the	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34049	A. BUILDING: _____ B. WING _____	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03090	Continued From page 17 entrance lacked the required notice for electronic monitoring. On August 5, 2024, at approximately 10:35 a.m. during a facility tour, clinical nurse supervisor (CNS)-B stated monitoring cameras were used at the facility and was not aware of the required verbatim notice to be posted at the entrances accessible by visitors. CNS-B also stated the required electronic monitoring posting would need to be placed at the entrance. The licensee's Electronic Monitoring policy dated January 1, 2020, indicated the licensee would comply with the Minnesota Electronic Monitoring law. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/06/24*
Time: 11:20:00
Report: 1013241062

Food and Beverage Establishment Inspection Report

Location:

Home Joy Home Care Of 83
7632 83rd Avenue North
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:

ID #: 0037965
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633605991
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.

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OPEN PACKAGE OF COTTO SALAMI WITHOUT A DATE MARK WAS LOCATED INSIDE THE DOWNSTAIRS REFRIGERATOR. THE SALAMI WAS PAST THE EXPIRATION DATE. DISCUSSED DATE MARKING PROCEDURES AND FOOD WAS DISCARDED.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

FACILITY'S DISH MACHINE SANITIZES WARE WITH HOT WATER. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH ABOVE RULE. DISCUSSED SANITIZER TESTING PROCEDURES WITH STAFF.

Comply By: 08/20/24

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO SOAP WAS AVAILABLE AT THE HAND WASHING SINK. STAFF STOCKED SOAP.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COOKED CHICKEN AND RICE WERE STORED IN THE KITCHEN REFRIGERATOR. PER STAFF THE FOOD WAS COOKED THEN COOLED 2 DAYS PRIOR. COMPLY WITH ABOVE RULE. DISCUSSED SAME DAY SERVICE WITH STAFF. FOOD WAS REMOVED.

Comply By: 08/06/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

GRIME BUILD UP WAS LOCATED ON THE SIDE OF THE KITCHEN ISLAND AND ON CABINET DOORS. DISCUSSED CLEANING PROCEDURES WITH STAFF.

Comply By: 08/12/24

Surface and Equipment Sanitizers

Hot Water: = at 150 Degrees Fahrenheit
Location: Residential dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Downstairs refrigerator
Violation Issued: No

Process/Item: Salami
Temperature: 40 Degrees Fahrenheit - Location: Downstairs refrigerator
Violation Issued: No

Process/Item: Chicken
Temperature: 39 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator C. Samrock.

The establishment has a residential kitchen. The kitchen has wood cabinets, vinyl floor, painted and tiled walls, solid counter top, and a tile ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Type: Full
Date: *08/06/24*
Time: 11:20:00
Report: 1013241062
Home Joy Home Care Of 83

Food and Beverage Establishment Inspection Report

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, food storage, and food handling procedures.

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 1013241062 of 08/06/24.

Certified Food Protection Manager: Jeanel Mouelle

Certification Number: 114138 Expires: 12/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Germaine Mouelle
Operator

Signed: JM

Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us