Electronically Delivered

October 22, 2026

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

RE: Project Number(s) SL34049016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 24, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	34049	A. BUILDING: _____ B. WING _____	09/24/2026

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#34049016-0 On September 21, 2026, through September 24, 2026, 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 two (2) residents; 2 receiving services under the Assisted Living license. On September 22, 2026, immediate correction orders were issued for tag identifications 0470 and 2310. During the course of the survey, the licensee took action to mitigate the imminent risks. Noncompliance remained and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed August 9, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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	0 340		

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0 340	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 12, 2024, the licensee received an enforcement letter, with the results of the licensee's previous survey completed on August 9, 2024. The longest time for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their survey results, or August 30, 2024. On September 21, 2026, through September 24, 2026, the surveyor conducted a survey on the licensee. As a result of the survey, the licensee was not in substantial compliance with tag identifications 0650 and 0680, and the orders were reissued. On September 21, 2026, at approximately 3:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee worked on a plan of correction for the correction orders from the previous survey but did not know where the document was. The Minnesota Department of Health (MDH) Correction Order Documentation Guidelines, dated January 3, 2023, indicated, correction order documentation should include the following: -identify how each order was corrected related to each individual client(s)/employee(s) identified in the order; -identify how each order was corrected for all the provider's clients/employees identified in the order; and	0 340		

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0 340	Continued From page 3 -identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute. Include information about how the provider will maintain compliance in the future. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the	0 470		

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0 470	Continued From page 4 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a minimum of two direct-care staff were scheduled and available to assist at all times whenever a resident required the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs; additionally, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) at least twice a year. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 the residents). The findings include: The licensee held a provisional assisted living facility license staffed with seven (7) personnel - licensed assisted living director (LALD)-A, CNS-B, and five (5) unlicensed personnel (ULP). The licensee was licensed for a bed capacity of four (4) residents and had a current census of two (2) residents. On September 21, 2026, at approximately 9:45 a.m., upon entrance to the facility, the surveyor observed the facility's main entrance had a split entry landing with stairs leading up to an	0 470	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remained unchanged.	

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0 470	Continued From page 5 upper-level and stairs leading down to a lower-level walkout. The upper-level stairs had a stair lift installed. The lower-level had a wheelchair ramp connected to a door that exited to a backyard patio. STAFFING On September 21, 2026, at approximately 11:00 a.m., during a facility tour, the surveyor observed the licensee's biweekly staff schedule, dated September 17 through September 30, posted in the upper-level hallway adjacent to the living room. The staff schedule indicated each day that one ULP was scheduled from 7:00 a.m. to 7:00 p.m. and one ULP was scheduled from 7:00 p.m. to 7:00 a.m. The staff schedule also indicated CNS-B worked Monday through Friday 9:00 a.m. to 6:00 p.m. and LALD-A worked Saturday and Sunday 9:00 a.m. to 6:00 p.m. On September 21, 2026, at 11:05 a.m., CNS-B confirmed the posted schedule was the most current staff schedule for the licensee. CNS-B also confirmed that 2 licensee staff were on site at the facility from 9:00 a.m. to 6:00 p.m. and one licensee staff was on site at the facility from 6:00 p.m. to 9:00 a.m. R1 was admitted on June 21, 2023, with diagnoses that included cerebral infarction (stroke) with left sided hemiplegia (loss of movement) and generalized muscle weakness. R1 resided in bedroom number 4 located in the lower level of the facility. R1's Resident Care Plan dated January 23, 2026, indicated R1 was non-ambulatory and needed a two-person assist with all activities of daily living (ADL), turning and repositioning in bed, and using a mechanical lift (Hoyer) when transferring R1	0 470		

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0 470	Continued From page 6 from R1's hospital bed to a wheelchair. R1's Assessment dated June 26, 2026, indicated R1 needed a two-person assist with total cares and using a Hoyer lift for transfers. R1's Service Plan dated January 23, 2026, indicated R1 needed a two-person assist with total cares and using a Hoyer lift for transfers. R1's Emergency Evacuation Plan, undated, indicated R1 could not reach a safe place independently in time of an emergency, was bed bound, and needed a two-person assist to transfer R1 from R1's bed to a wheelchair for an evacuation. On September 21, 2026, at approximately 2:30 p.m., CNS-B and ULP-C stated R1 needed a two-person assist with all cares and transfers. On September 21, 2026, at approximately 3:00 p.m., CNS-B stated for the hours between 6:00 p.m. and 9:00 a.m., when the licensee had only one staff person onsite, the licensee had available staff that lived close to the facility and could be called in to come onsite to assist with cares or an emergency evacuation for R1. STAFFING PLAN On September 21, 2026, at approximately 10:15 a.m., during the entrance conference, CNS-B stated each day that one ULP was scheduled from 7:00 a.m. to 7:00 p.m. and one ULP was scheduled from 7:00 p.m. to 7:00 a.m. CNS-B also stated she worked Monday through Friday 9:00 a.m. to 6:00 p.m. and LALD-A worked Saturday and Sunday 9:00 a.m. to 6:00 p.m. On September 21, 2026, at approximately 10:20	0 470		

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0 470	Continued From page 7 a.m., CNS-B stated the licensee lacked a written staffing plan that included an evaluation completed by CNS-B at least twice a year and they were unaware of the staffing plan requirement. The licensee's Staffing and Staffing Plan policy dated January 1, 2026, indicated the licensee would always schedule qualified staff to meet every resident's assessed, scheduled, and reasonably foreseeable unscheduled needs. The policy also indicated the CNS would develop, implement, and evaluate the staffing plan at least twice a year. Minnesota Administrative Rule 4659.0180, Subpart 3 dated August 11, 2021, indicated the clinical nurse supervisor must develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the clinical nurse supervisor must ensure that staffing levels were adequate to address the following: a. each resident's needs, as identified in the resident's service plan and assisted living contract; b. each resident's acuity level, as determined by the most recent assessment or individualized review; c. the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; d. whether the facility has a secured dementia care unit; and e. staff experience, training, and competency. Minnesota Administrative Rule 4659.0180,	0 470		

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0 470	Continued From page 8 Subpart 5 dated August 11, 2021, indicated a minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and	0 480		

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0 480	Continued From page 9 clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 480		

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0 480	Continued From page 10 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 21, 2026, for the specific Minnesota Food Code violations. The FBEIR was provided to the licensee via email on September 24, 2026. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	0 650		

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 _____	09/24/2026

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
0 650	Continued From page 11 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (clinical nurse supervisor (CNS)-B, 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 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 September 21, 2026, at approximately 10:15 a.m., during the entrance conference, CNS-B stated they were responsible for all the licensee's onboarding, training, and evaluation requirements for the licensee. CNS-B CNS-B was hired on May 5, 2016. CNS-B's employee record lacked documentation of a job description, completed annual training for 2025, and a performance evaluation for 2025. ULP-C	0 650		

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0 650	Continued From page 12 ULP-C was hired on October 1, 2022. ULP-C's employee record lacked documentation of a job description. On September 21, 2026, at approximately 3:15 p.m., CNS-B stated they completed the annual training for 2025 with staff but forgot to document it and was unsure why. CNS-B also stated they are awaiting licensed assisted living director (LALD)-A to return from being out of the country to complete the performance evaluation. CNS-B further stated that none of the licensee's employees had a job description in their file and was an oversight. The licensee's Personnel Records policy, undated, indicated the licensee would include the required job description, annual performance evaluation, and annual training documents in the employee's records. 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;	0 680		

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0 680	Continued From page 13 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP, dated August 20, 2023, lacked the following required content:	0 680		

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0 680	Continued From page 14 -maintain and annual EPP updates; -facility risk assessment; -missing resident plan reviewed quarterly; -process for emergency preparedness collaboration; -policies and procedures for development of EPP; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking staff and residents; -policies and procedures including evacuation; -policies and procedures for sheltering in place; -policies and procedures for medical documents; -policies and procedures for volunteers; -policies and procedures for arrangements with other facilities; -policies and procedures for roles under a waiver declared by secretary; -primary and alternate means for communication; -methods for sharing information; -procedure for sharing information on occupancy and or needs; -long term care family notifications; and -emergency prep testing requirements. On September 21, 2026, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee was still working on updating their EPP to be compliant with state requirements. CNS-B verified the licensee's EPP lacked the above listed required content. The licensee's Emergency Preparedness Evacuation policy, undated, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities	0 680		

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0 680	Continued From page 15 shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 775		

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0 775	Continued From page 16 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety)	0 790		

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0 790	Continued From page 17 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, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 18 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, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 19 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations	0 810		

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0 810	Continued From page 20 related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 21 by: Based on interview and record review, the licensee failed to ensure the residents' service plan included all required content 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 the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed for a bed capacity of four (4) residents and had a current census of two (2) residents. On September 21, 2026, at approximately 10:10 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated they were responsible for developing and maintaining the licensee's resident service plans. R1 R1 was admitted on June 21, 2023. On September 21, 2026, at approximately 2:00 p.m., R1's signed service plan dated January 23, 2026, was provided by CNS-B and indicated as R1's current service plan with services R1 was receiving. R1's service plan lacked the required content of fees for services, contingency plan on action taken if the scheduled service cannot be provided and contact information of persons the resident wishes to have notified in an emergency.	01650		

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01650	Continued From page 22 R2 R2 was admitted on October 6, 2021. On September 21, 2026, at approximately 3:00 p.m., R2's signed service plan dated January 27, 2026, was provided by CNS-B and indicated as R2's current service plan with services R2 was receiving. R2's service plan lacked the required content of fees for services, contingency plan on action taken if the scheduled service cannot be provided and contact information of persons the resident wishes to have notified in an emergency. On September 21, 2026, at approximately 3:30 p.m., CNS-B confirmed R1 and R2's service plans lacked content on fees for services, contingency plan on action taken if the scheduled service cannot be provided and contact information of persons the resident wishes to have notified in an emergency. CNS-B stated they did not realize the licensee was using an outdated form for the residents' service plans and needed to update their service plans to include all the required content. The licensee's Service Plan policy, undated, indicated the residents' service plans would include the fees for services, contingency plan, and emergency contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 23 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R1, R2) who utilized hospital bed side rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 September 21, 2026, at approximately 11:15 a.m., during facility tour, the surveyor observed a hospital style bed with bilateral (both sides of the bed) upper ½ side rails on R1 and R2's hospital beds. On September 21, 2026, at approximately 11:20 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2 used side rails for safety while they were resting in bed and when cares were provided by the licensee. R1 R1 was admitted on June 21, 2023, with	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remained unchanged.	

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02310	Continued From page 24 diagnoses that included cerebral infarction (stroke) with left sided hemiplegia (loss of movement) and generalized muscle weakness. R1's Resident Care Plan dated January 23, 2026, indicated R1 was non-ambulatory and needed full assistance with all activities of daily living (ADL), turning and repositioning in bed, and using a mechanical lift (Hoyer) when transferring. R1's Assessment dated June 26, 2026, indicated R1 needed full assistance with all cares and needed a Hoyer for transfers. R1's Side-Rail Use Assessment Form dated February 9, 2024, was provided by CNS-B and stated the document was R1's current side rail assessment. R1's side rail assessment lacked documentation of the zone measurements per the Food and Drug Administration (FDA) guidelines for zones one (1) through four (4) of entrapment and if the side rail were FDA compliant. R1's record also lacked ongoing side rail assessments. R2 R2 was admitted to the licensee on October 6, 2021, with diagnosis that included schizophrenia (mental health disorder that affects how a person thinks, feels, and behaves, often causing them to lose touch with reality) and was legally blind. R2's Assessment dated June 19, 2026, indicated R2 needed full assistance with all ADLs. R2's Side-Rail Use Assessment Form dated January 26, 2026, indicated the assessment lacked documentation of the zone measurements per the FDA guidelines for zones 1 through 4 of	02310		

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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
02310	Continued From page 25 entrapment and if the side rail was FDA compliant. R2's record also lacked ongoing side rail assessments. On September 21, 2026, at approximately 3:15 p.m., CNS-B confirmed R1 and R2's side rails safety zones 1 through 4 were not measured and were not verified if the side rails were FDA compliant. CNS-B stated they were unaware of side rail's zones of entrapment and the requirement to assess the zones of entrapment with documented measurements and to verify if the side rails were FDA compliant. The licensee's Side Rail Assessment policy, undated, indicated the licensee would assess all potential entrapment zones with bed rails to ensure resident safety. The FDA's A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website dated August 13,	02310		

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 _____	09/24/2026

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
02310	Continued From page 26 2026, indicated documentation about a resident's hospital side rails should include specific measurements of zones of entrapment and side rails must be assessed with each 90-day assessment and change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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

Food & Beverage Inspection Report

Establishment Info

Home Joy Home Care
7632 83rd Ave N
Brooklyn Park, MN 55445
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34049

Risk:
License:
Expires on:
CFPM: Jeanel Karline Mouelle
CFPM #: 17609; Exp: 10-9-2028

Inspection Info

Report Number: F1062261215
Inspection Type: Full - Single
Date: 9/21/2026 Time: 10:50 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: No illness log available on site during inspection. Ensure illness log is maintained available on site.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT: Observed clear plastic shaker container with torn off stickers in kitchen. It was filled with a white powder. Staff indicated it was salt. Ensure containers of food ingredients are labeled with name of food contained within.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

New Order: 4-100 Equipment Construction Materials
4-101.17 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.
COMMENT: Observed wooden spoons and a wood cutting board in kitchen. Comply with rule above.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

Food & Beverage General Comment

Inspection conducted on behalf of Carl Samrock of HRD.

Facility uses residential kitchen. Granite counters, wood panel floor, tiled walls, 2 basin sink left side dedicated to handwashing.

Discussed illness recording, leftover prohibitions, approved utensil materials, and labels for food containers.

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

I acknowledge receipt of the Metro District Office inspection report number F1062261215 from 9/21/2026

Jeanel Mouelle
Operator

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Home Joy Home Care
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1062261215
Inspection Type: Full
Date: 9/21/2026
Time: 10:50 am

Equipment Temperature: Product/Item/Unit: Fridge/freezer unit**; Temperature Process:** Ambient Air
Location: Fridge at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Home Joy Home Care
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1062261215
Inspection Type: Full
Date: 9/21/2026
Time: 10:50 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Equal To 170 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34049016-0	**Date:** September 22, 2026
Facility Name: Home Joy Care Inc	
Facility Address: 7632 83rd Ave N, Brooklyn Park, MN 55445	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Doors from individual dwelling or sleeping units of Group R occupancies having an occupant load of ten or less are permitted to be equipped with a night latch, dead bolt, or security chain, provided such devices are openable from the inside without the use of a key or tool. [Minn. Stat> 144G.45 subd. 2: MSFC 1010.1.9.4(4)]

   Comments: The front door to the facility was equipped with a lockable handle, Deadbolt, and a chain style night latch.

3. Door handles, pulls, latches, locks and other operating devices shall be installed 34 inches (864 mm) minimum and 48 inches (1219 mm) maximum above the finished floor. Locks used only for security purposes and not used for normal operation are permitted at any height. {Minn. Stat. 144G.45 subd. 2; MSFC 1010.9.2]

   Comments: The night latch that was installed on the front door to the facility was installed 64 inches above the finished floor.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguisher on the first floor landing was mounted at 74 inches above the finished floor. Fire extinguishers shall be mounted no higher that 60 inches to the top of the extinguisher.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: There was missing drywall and tile around the tub/shower in the first floor bathroom.

   There was missing door trim, and flooring at the base of the door for the first floor bathroom.

   There was a missing light globe in the first floor hallway.

   There was a missing light globe in the office.

   There was a missing light globe in the mechanical room.

   There were missing ceiling tiles in the mechanical room.

   There was a missing light globe in the lower level bathroom.

   There was a hole in the ceiling in the lower level bathroom in the shower.

   There was a missing light globe in resident room 4.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: Operations manager (OM)-D stated that they were not aware of a map in the FSEP in the policy book.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.

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

   Comments: OM-D stated that residents are given verbal instructions on evacuation procedures but lacked written instructions for residents to take in the event of a fire or similar emergency.

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

   Comments: OM-D provided what they stated was the documentation of staff training on the FSEP. The form was titled "Fire Drill Report" dated 12/20/2025 and did not contain any language that supported it being a training record. OM-D stated that other training documentation may be available, but they did not know where it was.

5. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: OM-D provided what they stated was resident training. The forms dated 6/18/26, 12/20/25, and 06/01/25 titled "Fire Drill" and did not contain any language that supported it being a training record.

6. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: OM-D stated that the drill and training were documented on the same form. Documentation that was provided showed that drills were conducted on 6/1/25, 12/20/25, and 6/18/26.