Electronically Delivered

August 21, 2026

Licensee
Rejoyce Health Care LLC
11361 Swallow Circle Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL40599015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 28, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40599	A. BUILDING: _____ B. WING _____	07/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REJOYCE HEALTH CARE LLC	11361 SWALLOW CIRCLE NORTHWEST COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40599015 On July 27, 2026, through July 28, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident(s); one receiving services under the Provisional Assisted Living Facility 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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

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0 480	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 28, 2026, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 485		

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0 485	Continued From page 4 a large portion or all the residents). The findings include: During the entrance conference on July 27, 2026, at 10:30 a.m., licensed assisted living director (LALD)-C confirmed she was familiar with the current minimum assisted living requirements. LALD-C stated the contract did include three meals but did not have an option to not accept all meals for a reduced charge. Licensee's resident agreement that is used by all residents included: Services included in the monthly rent RHC includes all services or amenities identified below in the monthly rent. If Tenant purchases a home care service package upon move-in, or if Tenant requires additional services after moving in, RHC will charge an additional fee based on the services or package purchased. Such services are described in Section 7 below. Pricing for services included in ret may be found on the attached price sheet. a. Home unit/room and monthly rent is three hundred dollars zero cent ($300) b. Three (3 meals per day and snacks meals c. Daily wellness check d. Outdoor surface parking, subject to availability for client guest e. Utilities - water, heat, electricity, sewer, air conditioning and trash service f. Basic cable TV g. Phone (not including long-distance charges) h. Internet, and other internet services not covered by RHC service, will be pay by client/tenant i. Opportunities for social and recreational activities (ex. Games)	0 485		

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0 485	Continued From page 5 j. Use and maintenance of the building including all common areas, including food k. Room repairs for normal wear and tear. Resident is responsible for reporting any needed repairs promptly. The assisted living contract lacked an option for residents to opt out of payment of meals for a reduced fee. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated April 17, 2026, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 510		

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0 510	Continued From page 6 Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for administration of injections. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 27, 2026 at 12:45 p.m., the surveyor observed clinical nurse supervisor (CNS)-A administere noon medications for R1 including insulin. CNS-A checked blood glucose with R1's continuous blood glucose monitor, checked the proper dosage of insulin on the electronic medication administration record (EMAR), dialed up correct dosage of insulin without priming the needle with 2 units of insulin, and applied a needle without cleaning the hub with an alcohol wipe. CNS-A administered insulin as ordered. CNS-A confirmed the steps taken to administer insulin and did not include cleaning the insulin pen hub with a alcohol wipe prior to applying the needle. The licensee's Insulin policy dated January 1, 2026, indicated an alcohol wipe should be used to clean the top of the insulin container. No further information was provided.	0 510		

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0 510	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=E	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 and interview, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 8 days	0 775		
0 800 SS=E	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 and interview, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the	0 800		

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0 800	Continued From page 9 physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	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 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.	0 810		

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0 810	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:	01530		

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01530	Continued From page 11 (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	01530		

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01530	Continued From page 12 Based on interview and record review, the licensee failed to ensure direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics effective July 1, 2025, for one of one employee (unlicensed personnel (ULP)-B). This had the potential to affect all residents and staff. 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: ULP-B began employment on January 12, 2026, to provide direct care to residents. ULP-B's employee record showed documentation of 0 hours of mental illness- de-escalation techniques and communication training. On July 28, 2026, at 3:45 p.m., clinical nurse supervisor (CNS)-A stated ULP-B did not have mental illness training, they do not have a policy for it, and they were not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40599	A. BUILDING: _____ B. WING _____	07/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REJOYCE HEALTH CARE LLC	11361 SWALLOW CIRCLE NORTHWEST COON RAPIDS, MN 55433

(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
01650	Continued From page 13 (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 by: Based on observation, interview and record review, the licensee failed to ensure resident service plans included all the required content 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	01650		

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01650	Continued From page 14 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: R1 was admitted to the licensee on January 12, 2026. R1's service plan dated July 11, 2026, indicated R1 received assistance with dressing, grooming, meal preparation, and medication administration. R1's service plan failed to include fees for services. On July 28, 2026, at 2:20 p.m, clinical nurse supervisor (CNS)-A confirmed the service plan signed by R1 did not have fees for services. The licensee's Service Plan policy dated January 3, 2026, indicated the service plans shall include fees for the services indicated in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must	01760		

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01760	Continued From page 15 include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on January 12, 2026. R1's service plan dated July 11, 2026, indicated R1 received assistance with dressing, grooming, meal preparation, and medication administration. R1's medication administration record dated July 2026, included to inject 4-12 units of insulin	01760		

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01760	Continued From page 16 aspart subcutaneously three times a day before meals per sliding scale. On July 27, 2026 at 12:45 p.m., the surveyor observed clinical nurse supervisor (CNS)-A administer noon medications for R1 including insulin. CNS-A checked blood glucose with R1's continuous blood glucose monitor, checked the proper dosage of insulin aspart on the electronic medication administration record (EMAR), dial up correct dosage of insulin. CNS-A failed to prime the needle with 2 units of insulin. CNS-A confirmed she drew up the 10 units of insulin as ordered per sliding scale, but did not state she primed the needle prior to administering. On July 28, 2026 at 3:55 p.m., CNS-A stated she did prime the needle prior to administering the medication. CNS-A stated she drew up 2 units of insulin by the sharps container outside of the resident's room, placed a needle on the pen, wasted the 2 units of insulin, removed the primed needle and placed a fresh, unprimed needle on the pen before administering. CNS-A confirmed she did not reprime the new needle with 2 units of insulin prior to administering the 10 units as ordered. The licensee's undated Insulin Administration policy, indicated to prime insulin and waste 2 units prior to drawing up the appropriate dose as ordered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01770	Continued From page 17	01770		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure accurate documentation of medication set up that included all required content for one of one residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 was admitted to the licensee on January 12, 2026. R1's service plan dated July 11, 2026, indicated R1 received assistance with dressing, grooming, meal preparation, medication set up and medication administration. R1's July medication administration record (MAR) included Senexon-s 8.6-50 mg (a laxative used to treat constipation) tab take 2 tablets twice a day. Order for Senexon-S had an end date of July 8,	01770		

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01770	Continued From page 18 2026. MAR included R1 received his 7 a.m. dose of Senexon-S on July 3 and July 4 and his 8 p.m. dose on July 2, July 3, and July 5. R1's medication set up report for July 1, 2026 to July 31, 2026, failed to include documentation of set up for Senexon-S. Medication set up report did include set up for Insulin Aspart (a short acting insulin) Injection for all days in July and Lantus Solostar (a long-acting insulin) injection for all days in July. No dose was listed for either injection set up. On July 28, 2026, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated she sets up all medication into a pill bar once a month or as needed. CNS-A stated she does not set up anything with the injectable medications, including insulin. The injectable medications was drawn up each time the medication was given. CNS-A stated she included these on the medication set up because she confirmed the correct inulin pen was available. CNS-A stated she was unsure why the Senexon-S was not included on the medication set up report for July but stated she was sure he received the medication. The licensee's Medication Management Dosage Box Set Up policy dated January 3, 2026, indicated the licensed nurse would set up a resident's dosage box timely and accurately. For medications that cannot be set up in dosage box (topical or liquid) would be recorded on the MAR to include any special instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments permitted only authorized personnel to access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On July 27, 2026 at 12:45 p.m., the surveyor observed clinical nurse supervisor (CNS)-A administer medications for R1. CNS-A removed R1's medications from a locked compartment and removed a box of medication cards and medications set up in mediset. CNS-A removed noon dose of medications from mediset and brought medications to R1's room. CNS-A left unsecured box of medications in unlocked nurses office while in R1's room. On July 28, 2026 at 3 p.m., medication	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 20 refrigerator was observed to not have a lock or way to secure medications. Clinical nurse supervisor (CNS)-A confirmed the refrigerator did not have a lock on it. CNS-A stated she purchased a lock but was unsure how to install it. Medication refrigerator had medication for one resident (R1) which included: - Flex touch pen insulin aspart: 30 - 3 ml pens - Lantus solostar pen: 8 pens Licensee's Medication Storage policy dated January 3, 2026, indicated medications would be kept securely locked and stored per manufacturer's direction and allow access to only authorized staff. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

REJOYCE HEALTH CARE LLC
11361 Swallow Circle NW
Coon Rapids, MN

Anoka County
Parcel:

Phone:

License Info

License: HFID 40599

Risk:
License:
Expires on:
CFPM: Monjue Assibu
CFPM #: CFPM-56928; Exp: 3/23/2028

Inspection Info

Report Number: F1039261196
Inspection Type: Full - Single
Date: 7/28/2026 Time: 12:30 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-103.11D,G,H,I,K,M *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0035DGHIKM The person in charge must ensure employees follow proper food handling procedures, including: effectively wash their hands; prevent cross-contamination of ready-to-eat food with bare hands by using suitable food utensils such as deli tissue, spatulas, tongs, single-use gloves, or proper dispensing equipment; properly cook TCS foods and verify cooking temperatures with a temperature measuring device; properly cool TCS foods that will not be held hot or consumed within 4 hours; maintain TCS foods at proper hot and cold holding temperatures; plumbing cross connection control, and properly sanitize cleaned multiuse equipment and utensils by monitoring the exposure time and concentration of the chemical sanitizing rinse solution, or by monitoring the exposure time and temperature for hot water sanitizing.
COMMENT: THERMO TEST STICKER WAS DESTROYED DURING AUTOMATIC WAREWASHING. USE TO DURABLE TEMPERATURE MEASURING DEVICE TO CONFIRM AUTOMATIC WAREWASHING MACHINE ACHIEVES A RINSE TEMPERATURE OF AT LEAST 160 DEGREES F.
Comply By: 8/7/2026 Originally Issued On: 7/28/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: OBSERVED A WET WIPING CLOTH HANGING ON EDGE OF SINK BASIN. INSTRUCTED STAFF TO DISCONTINUE THIS PRACTICE.
Comply By: 7/28/2026 Originally Issued On: 7/28/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: DIGITAL FOOD PROBE THERMOMETER DOES NOT FUNCTION. REPLACE BATTERY TO MAKE FUNCTION OR PROVIDE NEW PROBE THERMOMETER.
Comply By: 8/7/2026 Originally Issued On: 7/28/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: THERMO TEST STICKER DID NOT SURVIVE WAREWASHING CYCLE. ACQUIRE STICKER OR IRREVERSIBLE THERMOMETER WHICH WILL SURVIVE WAREWASHING CYCLE.
Comply By: 8/7/2026 Originally Issued On: 7/28/2026

Food & Beverage General Comment

AMBIENT - COOLER - 40 DEGREES F
FREEZER - FROZEN

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Wendy Robarge.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and stone countertops, tile floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair, clean and well maintained.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is used for warewashing, see order on temperature testing.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, all orders on this report.

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 F1039261196 from 7/28/2026

Rejoyce Tarr
person-in-charge

Aron Goodner,
Public Health Sanitarian
651-201-4910
aron.goodner@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

REJOYCE HEALTH CARE LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1039261196
Inspection Type: Full
Date: 7/28/2026
Time: 12:30 PM

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** Spray Bottle
Location: Equal To 50 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL40599015-0	**Date:** July 27, 2026
Facility Name: Rejoyce Health Care LLC	
Facility Address: 11361 Swallow Circle NW, Coon Rapids, MN 55433	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern **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. A means of egress shall be free from obstructions that would prevent its use. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: When the double hung style egress windows in unoccupied bedrooms one and four were opened by the licensee, these windows would not stay open to provide at least twenty inches clear open height. Egress windows that do not stay open would delay exiting in the event of a fire or similar emergency.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: An extension cord was plugged into a power strip in occupied resident bedroom five, creating a fire hazard.

☒ **TAG IDENTIFICATION: 0800**

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

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:
- Hot water was not provided at the bathroom and kitchen sink faucets. The licensee stated there was hot water last night and did not know why there was no hot water.
- The water drained very slowly from both bathroom sinks on the main floor.
- In the basement bathroom, the wall was damaged behind the toilet, one section of base cove was missing, and the toilet paper holder was broken.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern **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 employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments:
   -The licensee failed to develop all parts of the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the assisted living building. A third party RACE (Remove, Alarm, Confine, Extinguish/Evacuate) template was used that inaccurately directed employees to use pull fire alarms.
   - The emergency evacuation floor plans failed to identify the basement office and clearly label the main exit door for the building.

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

   Comments: The instructions for residents in case of fire failed to include written procedures for use of emergency escape and rescue openings (egress windows) in their bedrooms.