Electronically Delivered

October 24, 2023

Licensee
Always Amazing Home Care LLC
8225 Halifax Court North
Brooklyn Park, MN 55443

RE: Project Number(s) SL39403015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 28, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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
Per 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 residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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

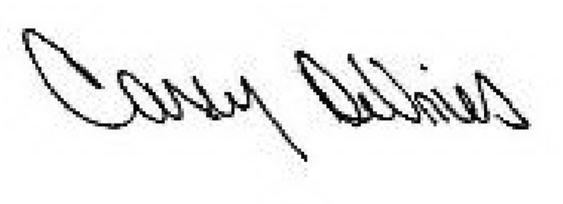
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	39403	A. BUILDING: _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALWAYS AMAZING HOME CARE LLC	8225 HALIFAX COURT NORTH BROOKLYN PARK, MN 55443

(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: SL39403015-0 On September 25, 2023, through September 28, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three active residents; all of whom were receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 1 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of three employees, (unlicensed personnel (ULP-D) and licensed assisted living director (LALD)-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 660		

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0 660	Continued From page 2 The findings include: ULP-D ULP-D was hired into the ULP role on February 13, 2023, to perform direct care services to the licensee's residents. ULP-D's employee records lacked evidence of screening for active TB with either a two-step TST or blood test. On September 26, 2023, at approximately 1:20 p.m., the surveyor observed ULP-D assisting R3 with getting food and escorting R3 in a wheelchair back to R3's room. LALD-C LALD-C was hired into the registered nurse and LALD roles on October 26, 2022, and performed direct care services to the licensee's residents. ULP-D's employee records lacked evidence of screening for active TB with either a two-step TST or blood test. On September 26, 2023, at approximately 1:10 p.m., the surveyor observed LALD-C assisting R3 with medication administration. On September 26, 2023, at approximately 9:00 a.m., the housing director (HD)-A stated, "We thought we only needed to do a chest x-ray and that would be good. So, you will find that issue for everyone because we don't do the blood test or the skin test, we have just been doing x-rays for everyone." The licensee's 8.16 Tuberculosis Screening policy dated November 1, 2022, read, Screening	0 660		

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0 660	Continued From page 3 will be conducted as follows: 1. New staff will be screened for active signs of TB using the baseline TB screening tools for HCW's. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the baseline TB screening tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results from the first manteau are read and documented or a negative IGRA blood test result is received since documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 4 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 emergency disaster preparedness plan lacked evidence of the following required content: - Risk assessment that considered hazards like care related emergencies, equipment/utility	0 680		

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0 680	Continued From page 5 failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - Categorize the various probable risks/hazards by likelihood of occurrence; - Strategies for addressing facility & community-based risks; - Identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care. - Identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - Include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - Develop and implement EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; - address the following whether evacuated or shelter in place for staff/residents: -Food, water, medical supplies, pharmaceutical supplies; -Alternate sources of energy to maintain: -Temperatures to protect resident health/safety; -Safe/sanitary storage of provisions; -Emergency lighting; -Fire detection, extinguishing, alarm systems; and -Sewage and waste disposal; - Develop P/P to shelter in place for residents, staff, and volunteers who remain in the facility; - Develop P/P to address: system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - Develop P/P that must address: use of volunteers, including the process/role for integration; - Develop P/P to address role of facility under a	0 680		

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0 680	Continued From page 6 waiver declared by the Secretary in accordance with section 1135 of the Act; - Develop a written communication plan; - Communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - Communication plan must include contact information for the following: - Federal, State, tribal, regional & local EP staff; - State Licensing and Certification Agency; - MN Office of Ombudsman for LTC; - Other sources of assistance; - Communication plan must include: primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; - Communication plan must include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - Conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: - Participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed.	0 680		

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0 680	Continued From page 7 On September 25, 2023, at 1:31 p.m., housing director (HD)-A acknowledged they did not have the missing items and stated, "I've learned a lot, and I am going to get everything I need to make sure it is all done correctly and put into a binder, so everything is together." The licensee's Emergency Plan policy dated November 1, 2022, indicated the licensee conducts a thorough Hazard Vulnerability Analysis to help determine what events or incidents may negatively impact its operations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 28, 2023, at approximately 9:45 a.m. with housing director (HD)-A it was observed that the window crank handle on the emergency escape and rescue opening in resident room #3 was broken and came apart from the window. The window did open during the tour, but the handle would not stay attached to the window. Emergency escape and rescue window opening crank handles are required to be maintained so operation of the window is available at all times for escape in the event of a fire or similar emergency. It was also observed that exterior trim was missing at the top of the windows exposing the weather barrier membrane. The exterior window trim is required to be maintained to create protection for the weather barrier membrane and intrusion of water into the exterior wall assembly. An electrical box cover was observed missing on the exterior of the building to the left of the front door. Electrical box covers are required to be maintained as installed and approved at the time of construction to protect from accidental contact to electrical wires and exposure to the elements. A fence was observed obstructing travel halfway into the clear space required at the bottom	0 800		

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0 800	Continued From page 9 landing of the exterior stairs leading off the deck. Landings at the top and bottom of stairs are required to be maintained to provide a clear space to enter and exit the stairway. These deficient conditions were visually verified by HD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 10 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on September 28, 2023, at approximately 11:00 a.m. of documents provided by housing director (HD)-A and licensed assisted living director (LALD)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee provided room numbers identifying the resident rooms on or adjacent to the door of the rooms but included	0 810		

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0 810	Continued From page 11 letters for identification in addition to the numbers. Resident room numbers only were observed on the fire safety and evacuation floor plan. Only one form of identification is required for use during an evacuation to reduce confusion of identification and location of resident rooms. Record review of the available documentation indicated that the licensee did not include fire protection procedures necessary for residents of this specific facility in the event of a fire or similar emergency. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Documentation of unique and unusual needs for evacuation of each resident in the facility is required to be kept with the fire safety and evacuation plan for reference in the event of a fire or similar emergency. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan and procedures. Facility fire safety and evacuation plan employee training is required to be completed and documented separately from drills. Record review of the available documentation indicated that evacuation drills had been conducted in the required numbers but not twice per year per shift. Documentation provided indicated all drills were completed on the day shift only. Evacuation drills are required to be completed and documented every other month and twice per shift per year and separately from	0 810		

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ALWAYS AMAZING HOME CARE LLC	8225 HALIFAX COURT NORTH BROOKLYN PARK, MN 55443

(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
0 810	Continued From page 12 employee training records. All deficiencies were verified by HD-A and LALD-C during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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	39403	A. BUILDING: _____ B. WING _____	09/28/2023

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01060	Continued From page 13 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's Signed Service Plan dated March 21, 2023, indicated R2 received services to include assistance with dressing, self-feeding, grooming,	01060		

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01060	Continued From page 14 toileting, bathing, standby assist, medication reminders, medication administration, transfers, eating assistance, personal laundry, housekeeping and linen changes, and safety checks. R2's nurse progress notes indicated R2 was hospitalized from September 14, 2023, through September 18, 2023. On September 26, 2023, at 12:53 p.m. licensed assisted living director (LALD)-C stated, "We don't have that form, when I think relocation, I think like a disaster relocation item. We can start doing that, but we have not ever done that." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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 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.	01760		

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	39403	A. BUILDING: _____ B. WING _____	09/28/2023

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01760	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document administration or refusal of medications according to provider orders for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Signed Service Plan dated March 21, 2023, indicated R2 received services to include assistance with dressing, self-feeding, grooming, toileting, bathing, standby assist, medication reminders, medication administration, transfers, eating assistance, personal laundry, housekeeping and linen changes, and safety checks. R2's medication administration record for September 2023, had missing charting for Baclofen 20 milligram (mg) tablet for the afternoon dose on September 1 and 5, 2023, and Systane 0.6 percent solution eye drops for afternoon doses on September 15-18, 2023, and HS (hour of sleep) dose on September 15, 2023. There was no reason written for why the medications were not given. On September 26, 2023, at 12:57 p.m., licensed assisted living director (LALD)-C stated "I tell	01760		

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01760	Continued From page 16 them [staff] all the time and I train them that if it [medications or treatments] is not documented it is not done, and then I train them some more that documentation is so important. It is always done the treatment or the medication pass, I know this because I go back and make sure but sometimes, they [staff] just forget to mark it down." The licensee's 7.15 Medication & Treatment - Administration & Delegation policy, dated November 1, 2022, indicated the staff were trained and competency trained to document medication administration or the reason for not assisting with medication administration as ordered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	01960		

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01960	Continued From page 17 Based on interview and record review, the licensee failed to ensure treatments were performed as ordered for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's Signed Service Plan dated March 21, 2023, indicated R2 received services to include assistance with dressing, self-feeding, grooming, toileting, bathing, standby assist, medication reminders, medication administration, transfers, eating assistance, personal laundry, housekeeping and linen changes, and safety checks. R2's treatment sheet/record for September 2023, had the following missing charting: - Suprapubic daily site care for September 8, 9, 11, 12, 22, and 23, 2023; - Urine output for AM shift on September 2, 4, 6-8, 11, 18, 22, 23, and 24, 2023; - Urine output for PM shift on September 1, 10-14, 16, 17, 19, 20, 22, and 23, 2023; - Urine output for overnight shift on September 1, and 3-24, 2023; - Bowel movement for AM shift on September 2, 4, 11, and 14-24, 2023; - Bowel movement for PM shift on September 1, 2, 4-8, 10-18, 22, and 23, 2023; - Wheelchair assistance for pressure relief for AM	01960		

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01960	Continued From page 18 shift on September 2, 4, 11, 14-24, 2023; and - Wheelchair assistance for pressure relief for PM shift on September 1, 4, 5, 10, 11, 13-18, 22, and 23, 2023. On September 26, 2023, at 12:57 p.m., licensed assisted living director (LALD)-C stated "I tell them [staff] all the time and I train them that if it [medications or treatments] is not documented it is not done, and then I train them some more that documentation is so important. It is always done the treatment or the medication pass, I know this because I go back and make sure but sometimes, they [staff] just forget to mark it down." The licensee's 7.05 Treatment & Therapy Management Plan, dated November 1, 2022 indicated the treatment and therapy management record would contain verification that all treatment and therapy was administered as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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

Type: Full
Date: *09/25/23*
Time: 12:00:00
Report: 1005231220

Food and Beverage Establishment Inspection Report

Location:
Always Amazing Home Care LLC
8225 Halifax Court
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0040069
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/HAM
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 35 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: 40 Degrees Fahrenheit - Location: GARAGE REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH FOOD MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR TESA BROWN.

IRREVERSIBLE TEMPERATURE STRIPS FOR THE DISHWASHER WERE ON SITE, ALTHOUGH THEY INDICATE A TEMPERATURE OF 180 DEGREES F. MANAGER SAID THAT THE DISHWASHER DOES REACH THAT TEMPERATURE WHEN THE STRIPS ARE RUN THROUGH. RECOMMEND GETTING STRIPS THAT INDICATE 160 DEGREES F INSTEAD, OR A MAXIMUM REGISTERING THERMOMETER, SINCE THE MINIMUM REQUIRED UTENSIL SURFACE

TEMPERATURE IS 160 DEGREES F.

DISCUSSED GLOVE USE, COOKING TEMPERATURES, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1005231220 of 09/25/23.

Certified Food Protection Manager: BEATRICE J. HINNEH

Certification Number: FM112488 Expires: 08/18/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
BEATRICE HINNEH

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us