Electronically Delivered

June 29, 2023

Licensee
Avid Home and Community Healthcare Services
2609 87th Trail North
Brooklyn Park, MN 55443

RE: Project Number(s) SL38795015

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 June 5, 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 and enforcement actions 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,

Paul T. Spencer

Paul Spencer, Supervisor
State Rapid Response Team
Email: paul.spencer@state.mn.us
Telephone: 651-587-4460 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38795	A. BUILDING: _____ B. WING _____	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVID HOME AND COMMUNITY HEALTHCARE S	2609 87TH TRAIL 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: SL38795015 On June 5, 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 no active residents; none receiving services under the Provisonal 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	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a 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 interview and record review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) infection control prevention program according to the most current guidelines issued by the Centers for Disease Control (CDC), which included a facility TB risk assessment. This had the potential to affect all residents receiving assisted living services, as well as staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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).	0 660		

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0 660	Continued From page 2 The findings include: During the entrance conference on June 5, 2023, at 11:00 a.m., with licensed assisted living director/registered nurse (LALD/RN)-A, a request was made to review the facility TB policy. Review of the licensee's TB policy on June 5, 2023, at 2:30 p.m., lacked evidence of a completed TB risk assessment. During an interview on June 5, 2023, at 3:00 p.m., LALD/RN-A stated the facility risk assessment had not been completed. The licensee's TB Risk Assessment Worksheet, dated April 17, 2023, indicated a worksheet had been initiated but did not contain the licensee's TB risk level or quality improvement which would include the date of the last TB risk assessment, how frequent to conduct or update the assessment. A policy titled Tuberculosis Screening, undated, indicated the licensee is to implement a system for facility assessment of risk of TB and provide testing in accordance with the assessment. The facility completes a risk assessment worksheet annually and keeps a copy in the facility files. TIME PERIOD TO CORRECT: 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	0 680		

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0 680	Continued From page 3 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a complete written emergency disaster plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 680		

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0 680	Continued From page 4 affect a large portion or all of the residents). The findings include: Review of the licensee provided Emergency Preparedness Policy, not dated, indicated the licensee would have an identified plan in place to assure safety and well-being of resident and staff during periods of emergency or disaster. The policy also indicated the licensee would implement the Emergency Management program as soon as the agency became aware of the existence of an emergency. Review of the licensee's provided Emergency Preparedness Manual lacked the following required content: - process for EP cooperation with state and local EP officials/organizations. - a thoroughly completed risk assessment; - arrangements/contracts to re-establish utility services; and - a description of the population served by the licensee. - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites.	0 680		

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0 680	Continued From page 5 - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. During an interview on June 5, 2023, at 1:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the policy provided to the surveyor is the current policy the licensee has in place. LALD/RN-A stated they do have a verbal agreement with another facility in the event of an emergency to relocate the residents providing the other facility would have openings at the time. A policy titled Emergency Management, not dated, identified the licensee would have a plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. TIME PERIOD TO CORRECT: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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0 780	Continued From page 6 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected throughout the facility. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 780		

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0 780	Continued From page 7 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 June 6, 2023, between 1:25 p.m. and 2:05 p.m., survey staff toured the facility with volunteer (VOL)-A. During the facility tour, survey staff observed that smoke alarms did not test as interconnected so that actuation of one alarm caused all alarms in the dwelling unit to operate in the following locations: 1. Sleeping room 4 in the basement 2. Sleeping room 2 on the second story 3. In the hallway outside the basement sleeping rooms Smoke alarms that are not interconnected in a dwelling unit would delay notification of the building occupants in the event of a fire. This deficient condition was verified by VOL-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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.	0 800		

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0 800	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, 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 the potential to affect a large portion or all of the residents). Findings include: On June 6, 2023, between 1:25 p.m. and 2:05 p.m., survey staff toured the facility with volunteer (VOL)-A. During the facility tour, survey staff observed the following: 1. A wall light fixture in the basement bathroom closet was hanging loose and not secured to the wall. 2. The receptacle for a sliding door chain lock was installed on the front door. 3. The laundry dryer vent was disconnected and no longer vented to the exterior of the building. 4. Drywall was patched but had not been painted or finished on the walls in several locations in the	0 800		

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0 800	Continued From page 9 facility. 5. Trim was not installed on the main floor bathroom door. The floor transition between the hallway and this bathroom was loose, creating a potential trip hazard. These deficient conditions were verified by VOL-A accompanying on the facility 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	0 810		

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0 810	Continued From page 10 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop fire safety and evacuation plans with the required elements and failed to provide employee and resident training on fire safety and evacuation. These deficient conditions had the potential to affect all staff, residents, 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 the potential to affect a large portion or all of the residents). Findings include: On June 6, 2023, between 1:25 p.m. and 2:05 p.m., survey staff toured the facility with volunteer (VOL)-A. During the facility tour, survey staff observed that the posted evacuation maps showed an emergency exit through the garage. Exits are required to be maintained and lead directly to the exterior and not through a higher hazard room.	0 810		

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0 810	Continued From page 11 On June 6, 2023, at approximately 12:50 p.m., VOL-A verified this deficient condition. On June 6, 2023, at approximately 2:05 p.m., records were provided for review by VOL-A. Records were reviewed by survey staff on June 6, 2023, between 2:05 p.m. and 2:25 p.m. 1. Record review of the available documentation indicated that the fire safety and evacuation plans had not been developed for the facility location. A template for workplace fire safety was provided. The template plan references sprinklers, which were not observed during the facility tour. The plans included vague instructions for employees and did not include complete employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location. 2. The fire safety and evacuation plans did not include fire protection procedures necessary for residents from this facility location. 3. The fire safety and evacuation plans did not include procedures for residents with unique or unusual needs for movement or evacuation during a fire or similar emergency. 4. Record review of the available documentation indicated that employee training on the fire safety and evacuation plans had not been documented. The VOL-A explained that they did not know where this documentation was located. 5. Record review of the available documentation indicated that annual training for residents capable of assisting in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation had not been documented. The VOL-A explained that they did not know where this documentation was	0 810		

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0 810	Continued From page 12 located. These deficient conditions were verified by VOL-A. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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

Type: Full
Date: *06/05/23*
Time: 12:00:00
Report: 1013231156

Food and Beverage Establishment Inspection Report

Location:
Avid Home and Community Health
2609 87th Trail N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0041328
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

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.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

A RESIDENTIAL DISH MACHINE IS USED TO SANITIZE WARE USING HOT WATER. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH ABOVE RULE.

Comply By: 06/12/23

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Butter
Temperature: 36 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator J. Serbus.

The establishment has a residential kitchen and serves food that is prepared that day. Currently there are no residents at the facility. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

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

A residential dish machine is located in the kitchen. Hot water sanitizing dish machine test strips were provided to test the dish machine.

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013231156 of 06/05/23.

Certified Food Protection Manager: Miriam Osammor

Certification Number: 116169 Expires: 04/16/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Miriam Osammor
Operator

Signed: JM

Jerry Malloy
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