Electronically Delivered

September 13, 2024

Licensee
AMA Group Home Inc
2607 Longfellow Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL35373015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35373	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMA GROUP HOME INC	2607 LONGFELLOW AVENUE SOUTH MINNEAPOLIS, MN 55407

(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: SL35373015-0 On August 12, 2024, through August 14, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; all receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 1 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content including 30-day supervision for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 650		

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0 650	Continued From page 2 The findings include: ULP-B was hired March 6, 2020, to provide direct care services to the licensee's residents. On August 13, 2024, at 8:30 a.m., ULP-B was observed administering prescribed medications to R1. ULP-B's record lacked evidence of 30-day supervision when performing delegated tasks. On August 14, 2024, at 12:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the required 30 days supervision of staff performing delegated tasks had been completed for all staff, but LALD/RN-A acknowledged ULP-B's record lacked documentation of 30-day supervision of delegated tasks. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 01, 2021, indicated "Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee's] and first performs the delegated tasks for residents and thereafter as needed based on performance.". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 790 SS=C	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 3 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the proper installation of the portable fire extinguishers. This had the potential to directly affect residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 12, 2024, from 1:30 p.m. to 2:30 p.m., survey staff toured the home with housing manager (HM)-C. During the tour, survey staff observed the portable fire extinguisher (PFE) units for the upper-level floor and inside the lower-level laundry room were not secured and mounted as required. The PFE units were placed on a shelf. The deficient findings were visually	0 790		

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0 790	Continued From page 4 and verbally verified by HM-C at the time of discovery. On August 12, 2024, at approximately 3:00 p.m., during the exit interview, survey staff explained the deficient findings to licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, 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	0 800		

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0 800	Continued From page 5 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 12, 2024, from 1:30 p.m. to 2:30 p.m., survey staff toured the home with housing manager (HM)-C. During the home tour, survey staff observed the following: -The licensee did not provide the required privacy provisions for resident sleeping room 3 and the upper-level bathroom door (adjacent to resident sleeping room 6). Survey staff explained that the resident sleeping room doors must have privacy locks or provisions must be made to provide for resident privacy. HM-C verified they lacked privacy provisions at the time of discovery. -Improper disposal of cigarette butts. Cigarette butts were discarded on the ground in the backyard next to the back door. Survey staff asked about the home's designated smoking area and a proper cigarette butt receptacle. HM-C confirmed the finding and stated that their designated smoking area is in the front of the house where they have provided an ashtray. HM-C stated that they would purchase a proper cigarette butt receptacle for disposal of cigarette butts. -No window screens were provided for resident rooms 3 and 4 to prevent entry of unwanted insects. The above deficient findings were verbally and visually verified by HM-C at the time of discovery during the home tour.	0 800		

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0 800	Continued From page 6 On August 12, 2024, at approximately 3:00 p.m., during the exit interview, survey staff explained the deficient findings to licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A understood and acknowledged the findings. No further information was provided. 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	0 810		

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0 810	Continued From page 7 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 12, 2024, from 1:30 p.m. to 2:30 p.m., survey staff toured the home with housing manager (HM)-C, survey staff observed the posted fire evacuation floor diagrams did not include room numbers for each resident bedroom. Evacuation plans must include the location and resident sleeping room numbers. HM-C verified they lacked the room numbers on the evacuation floor diagrams.	0 810		

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0 810	Continued From page 8 On August 12, 2024, at approximately 2:45 p.m., document and record review and interview with licensed assisted living director/registered nurse (LALD/RN)-A, on the home's fire safety and evacuation plan, revised and dated, January 22, 2024, and related training policies, procedures, and records indicated the following: -Document review indicated the licensee's plan did not include and identify specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. -Document review indicated the plan included standard employee fire safety policy but lacked complete and specific employee actions to take in the event of a fire or similar emergency relative to the employee responsibilities or basic evacuation procedures including immediate rescue of endangered individuals and/or residents from a fire or similar emergency. The above deficient findings were verified by LALD/RN-A during the interview. On August 12, 2024, at approximately 3:00 p.m., during an interview, survey staff explained the deficient findings to LALD/RN-A. LALD/RN-A understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 9 (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 interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of	01650		

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01650	Continued From page 10 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's Individualized Treatment or Therapy Management Plan dated January 10, 2024, indicated blood glucose check on Monday and Friday morning before breakfast. R1's records included documentation of blood glucose on Mondays and Fridays before eating from August 03 -August 12, 2024. R1's Service Plan dated January 2, 2024, lacked identification of blood glucose monitoring. On August 14, 2024, at 12:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A acknowledged R1's service plan was missing blood glucose monitoring and LALD/RN-A stated the resident service plan should include all services provided by the licensee. The licensee's 6.08 Service Plan policy dated July 20, 2021, indicated " A description of the services that are to be provided based on the most recent assessment and resident preferences". No further information was provided. Time period for correction: Twenty-One (21) days	01650		

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

Type: Full
Date: *08/13/24*
Time: 10:40:00
Report: 1013241063

Food and Beverage Establishment Inspection Report

Location:
Ama Group Home Inc
2607 Longfellow Avenue South
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0038096
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128861837
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

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

Food and Equipment Temperatures

Process/Item: Corn
Temperature: 29 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cheese
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator S. Hassan.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, wood floor, painted walls, solid counter top, and a painted ceiling.

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

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

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013241063 of 08/13/24.

Certified Food Protection Manager: Suad Hasan

Certification Number: 107539 Expires: 08/28/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Suad Hasan
Operator

Signed: JM

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