



STATE LICENSING COMPLIANCE REPORT

Report #: HL387958588C

Date Concluded: November 7, 2025

Avid Home Care
2609 89th Trail N
Brooklyn Park MN 55443
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

Or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38795 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/15/2025 |
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| 0 000 | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL387958588C</p> <p>On September 15, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 2 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued/orders are issued for #HL387958588C, tag identification 1070 and 1600.</p> | 0 000 | <p>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 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 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 evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p> | |
| 01070 SS=D | 144G.52 Subd. 10 Right to return | 01070 | | |

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| Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| 01070 | <p>Continued From page 1</p> <p>If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow one of one resident (R1) to return to the facility after a hospitalization.</p> <p>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).</p> <p>The findings include:</p> <p>R1 admitted to the licensee June 20, 2025, 2024. R1's diagnoses included post cerebrovascular accident (stroke), chronic kidney disease, unsteady gait, drug abuse and dementia with short term memory loss. R1's planned services dated June 20, 2025, included assistance with medication administration and mobility.</p> <p>A report dated June 24, 2025, indicated R1 was admitted to the emergency room on June 23, 2025 and the facility refused to take R1 back after the hospital deemed R1 cleared to return.</p> <p>A progress note dated June 20, 2025 at 4:30 p.m. indicated R1 was admitted to the facility but was oriented to person and place but not to</p> | 01070 | | |
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| 01070 | <p>Continued From page 2</p> <p>situation and as to why he was there. the note indicated the staff reminded R1 why he was admitted to the facility.</p> <p>A progress note dated June 21, at 2:06 p.m. R1 was asking to leave, staff unable to convince resident to stay but the nurse did talk R1 into staying.</p> <p>A progress note date June 21 at 6 p.m. indicated R1 was outside with belongings requesting to go home but was able to be persuaded into going back inside.</p> <p>A progress note date June 22, 2025, at 2 p.m., indicated R1 was outside with his belongings, threatening to leave. The note indicated R1 was confused about where he was. RN was able to talk R1 back inside of home. The progress note further indicated the RN promised R1 would be discharged/transferred the next day.</p> <p>The last progress note dated June 23, 2025 at 9:30 a.m. indicated R1 was transported, non-emergent, to a local emergency department for further evaluation.</p> <p>R1's medical record from the emergency department, dated June 23, 2025 indicated the resident was seen for mental health concerns but was not in need of inpatient stay. The medical record further indicated the resident had a history of neurocognitive disorder and behavior disturbance. The record further indicates the facility was refusing to take R1 back.</p> <p>A document titled Support plan, dated June 20, 2025, outlines the support R1 will need at the facility. The document stated R1 is experiencing</p> | 01070 | | |
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| 01070 | <p>Continued From page 3</p> <p>concerns with short term memory and had a SLUMS score of 16/30. The plan also states R1 frequently threatens to leave the hospital. The plan indicated R1 wanted to go home but that his wife was unable to care for him. The plan further indicates services for R1 were being funded under a brain injury wavier.</p> <p>R1's discharge summary from the facility indicated the reason for discharge was admit to hospital.</p> <p>During an interview on October 22, 2025, at 2:13 p.m., LSW-A stated the facility RN refused to take R1 back after the brief emergency room visit.</p> <p>During an interview on October 30, 2025 at 10:13 a.m., the RN-B stated she did not refuse to take R1 back, stating R1 wanted to go home. The RN-B further stated she was aware R1 had a stroke but was not aware of memory issues. RN-B further stated she did not go to see the resident for a pre-assessment, rather waiting until the resident arrived at the facility. RN-B also sated she did receive the hospital paperwork, including the support plan and had reviewed them prior to the resident arriving at the facility. RN-B also stated she did talk to CM-C prior to the resident's arrival about the cares he needed.</p> <p>During an interview on October 30, 2025, at 9:07 a.m. the CM-C stated she talked with RN-B and was advised on R1's memory issues and desire to return home but could not. The CM-C further stated RN-3 agreed to admit R1 knowing these concerns.</p> <p>A policy provided by the facility titled "Assisted living contract terminations" states that if a</p> | 01070 | | |
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| 01070 | Continued From page 4 resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. TIME PERIOD OF CORRECTION: Seven (7) days | 01070 | | |
| 01600 SS=D | 144G.70 Subdivision 1 Acceptance of residents An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the facility had sufficient staff to adequately provide the agreed upon services for one of one resident (R1) reviewed. The hospital provided documentation indicating R1 expressed desire to go home, and short term memory concerns while the facility documents indicate it can provide one-to-one staffing in certain circumstances. However, the facility admitted the resident without having sufficient staff to provide resident services for R1 when he required one to one staffing for mental health safety. This had the potential to impact all 30 residents currently receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an | 01600 | | |

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| 01600 | <p>Continued From page 5</p> <p>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).</p> <p>The findings include:</p> <p>R1 admitted to the licensee June 20, 2025, 2024. R1's diagnoses included post cerebrovascular accident (stroke), chronic kidney disease, unsteady gait, drug abuse and dementia with short term memory loss. R1's planned services dated June 20, 2025, included assistance with medication administration and mobility.</p> <p>A progress note dated June 20, 2025 at 4:30 p.m. indicated R1 was admitted to the facility but was oriented to person and place but not to situation and as to why he was there. the note indicated the staff reminded R1 why he was admitted to the facility.</p> <p>A progress note dated June 21, at 2:06 p.m. R1 was asking to leave, staff unable to convince resident to stay but the nurse did talk R1 into staying.</p> <p>A progress note date June 21 at 6 p.m. indicated R1 was outside with belongings requesting to go home but was able to be persuaded into going back inside.</p> <p>A progress note date June 22, 2025, at 2 p.m., indicated R1 was outside with his belongings, threatening to leave. The note indicated R1 was confused about where he was. RN was able to talk R1 back inside of home. The progress note further indicated the RN promised R1 would be discharged/transferred the next day.</p> | 01600 | | |

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| 01600 | <p>Continued From page 6</p> <p>The last progress note dated June 23, 2025 at 9:30 a.m. indicated R1 was transported, non-emergent, to a local emergency department for further evaluation.</p> <p>A document titled Support plan, dated June 20, 2025, outlines the support R1 needed at the facility. The document stated R1 is experiencing concerns with short term memory and had a SLUMS score of 16/30. The plan also stated R1 frequently threatened to leave the hospital. The plan indicated R1 wanted to go home but his wife was unable to care for him. The plan further indicates services for R1 were being funded under a brain injury wavier.</p> <p>The facility's Uniform Disclosure of assisted living services and amenities under section 9 Staffing, indicates the facility will provide one to one staffing for special circumstances.</p> <p>R1's medical record from the emergency department, dated June 23, 2025 indicated the resident was seen for mental health concerns but was not in need of inpatient stay. The medical record further indicated the resident had a history of neurocognitive disorder and behavior disturbance. The record further indicates the facility was refusing to take R1 back.</p> <p>The facility's staffing plan indicates that the facility has one staff member scheduled for 12 hour shift day or night.</p> <p>During an interview on October 30, 2025, at 10:13 a.m. register nurse (RN)-B stated the decision for acceptance of residents was bases on her assessment. RN-B further stated she did</p> | 01600 | | |
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| 01600 | <p>Continued From page 7</p> <p>not do a pre assessment on R1 but rather waited until he arrived at the facility. RN-B further stated she reviewed documents from the sending facility including the support plan and talked with nurses and case managers about R1 needs. RN-B also stated she was not aware of any memory issues for R1. RN-B further stated at when R1 would request to go home, she trained staff to redirect him but that did not work. RN-B further stated that R1 was not confused, he just wanted to go home. RN-B stated she understood R1 could not go home. RN-B stated all she did was tell staff to try to redirect him but that did not work and was not sure what else to try. RN-B also stated that if a staff member called out the shift, RN-B would have to work the shift.</p> <p>During an interview on October 30, 2025, case manager (CM-C) RN-B was made aware of R1's inability to return home and R1 attempt to leave the hospital prior to being admitted to the facility.</p> <p>During an interview on October 28, 2025, a family member (FM-D) stated the facility was not able to take care of R1 because he wanted to go home but could not as R1's wife was unable to care for him. FM-D also stated R1 had no short term memory and would often just keep repeating the same thing. FM-D further stated that he had gone to the facility and no staff were working. FM-D stated a resident let him in to the facility and stated no employee was working.</p> <p>A policy provided by the facility titled Resident admission policy, states upon the referral, a registered nurse or other licensed health professional shall evaluate each resident to determine appropriateness of assisted living services in accordance with the admission policy,</p> | 01600 | | |

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| 01600 | <p>Continued From page 8</p> <p>A policy provided by the facility titled Resident Admission Process, states the admission criteria are standards by which a potential resident can be judged for admission include the facility is capable of providing the needed care or service at the level of intensity required by the resident's condition.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p> | 01600 | | |