



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 14, 2024

Licensee

Amc Care Inc.

6601 75th 1/2 Avenue North

Brooklyn Park, MN 55428

RE: Project Number(s) SL36751015

Dear Licensee:

On April 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 20, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Robert Dehler', with a horizontal line extending to the right.

Bob Dehler, P.E.

Engineering Manager

Engineering Services Section

Health Regulation Division

Email: Robert.Dehler@state.mn.us

Telephone: 651-201-3710

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/24/2024
NAME OF PROVIDER OR SUPPLIER AMC CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6601 75TH 1/2 AVENUE NORTH BROOKLYN PARK, MN 55428			
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL36751015-1 On April 24, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 12, 2023 . At the time of the survey, there were 02 residents; 02 receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	{0 470}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{0 470}	Continued From page 1 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further actions required	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further actions required	{0 480}			
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks	{0 485}			

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{0 485}	Continued From page 2 available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further actions required	{0 485}			
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility	{0 550}			

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{0 550}	Continued From page 3 Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further actions required	{0 550}			
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: No further actions required	{0 570}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further actions required	{0 630}			

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{0 640}	Continued From page 4	{0 640}			
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further actions required	{0 640}			
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled 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	{0 650}			

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{0 650}	Continued From page 5 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: No further actions required	{0 650}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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: No further actions required	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}			

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{0 680}	Continued From page 6 (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; 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: No further actions required	{0 680}			
{0 690} SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.	{0 690}			

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{0 690}	Continued From page 7	{0 690}			
	This MN Requirement is not met as evidenced by: No further actions required				
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the	{0 730}			

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{0 730}	Continued From page 8 appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further actions required	{0 730}			
{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	{0 950}			

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{0 950}	Continued From page 9 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: No further actions required	{0 950}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	{01500}			

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{01500}	Continued From page 10 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further actions required	{01500}			

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{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further actions required	{01530}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	{01620}			

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{01620}	Continued From page 12 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further actions required	{01620}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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	{01650}			

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{01650}	Continued From page 13 (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: No further actions required	{01650}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	{01730}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/24/2024
NAME OF PROVIDER OR SUPPLIER AMC CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6601 75TH 1/2 AVENUE NORTH BROOKLYN PARK, MN 55428			
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{01730}	Continued From page 14 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further actions required	{01730}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 15 discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further actions required	{01910}			
{02240} SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may	{02240}			

Minnesota Department of Health

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{02240}	Continued From page 16 contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: No further actions required	{02240}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 8, 2024

Licensee

AMC Care Inc

6601 75th 1/2 Avenue North

Brooklyn Park, MN 55428

RE: Project Number(s) SL36751015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 20, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The 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 the 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>

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2023
NAME OF PROVIDER OR SUPPLIER AMC CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6601 75TH 1/2 AVENUE NORTH BROOKLYN PARK, MN 55428			
(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: SL36751015-0 On December 18, 2023, through December 20, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; with two receiving services under the 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee'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	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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 held an assisted living license and was licensed for a capacity of five residents with a current census of two residents. On December 18, 2023, at 12:45 p.m. the facility staffing plan was requested. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On December 18, 2023, at 12:45 p.m. clinical nurse supervisor (CNS)-C stated she and house manager (HM)-B had discussed the staffing need but had not developed a written staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 19, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 485			

Minnesota Department of Health

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0 485	Continued From page 4 (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents. 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 the residents). The findings include: On December 18, 2023, at 2:00 p.m. during a facility tour, a dry erase board located in the facility living room included that day's menu. Additionally, a bulletin board located in the kitchen area included various healthy food postings but lacked the required posting for the menu a week in advance. On December 18, 2023, at 2:10 p.m. house	0 485			

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0 485	Continued From page 5 manager (HM)-B stated the week's menu was usually posted, however, at this time, it was not. The licensee's Food Service policy dated July 30, 2021, indicated the menu would be prepared a week in advance and available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the	0 550			

Minnesota Department of Health

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0 550	Continued From page 6 contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 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 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 December 18, 2023, at 2:00 p.m. during a facility review of postings, the surveyor noted various postings on two bulletin boards on the upper level of the facility. The postings lacked the required information about the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. Additionally, the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and lacked information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On December 18, 2023, at 2:10 p.m. house manager (HM)-C stated the licensee usually gave the residents the forms; however, she had not posted the information in a conspicuous location as required.	0 550			

Minnesota Department of Health

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0 550	Continued From page 7 The licensee's Grievance policy dated July 30, 2021, indicated the licensee would post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all the licensee's current residents, staff, and visitors. 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 the	0 570			

Minnesota Department of Health

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0 570	Continued From page 8 residents). The findings include: On December 18, 2023, at 2:00 p.m. the surveyor observed the facility entrance area with house manager (HM)-B, and noted the license was not posted as required. HM-B stated the license was posted in the office area on the main level of the facility. The license was observed to be posted in the facility's locked office and had the effective date of October 1, 2023, and an expiration date of September 30, 2024. On December 18, 2023, at 2:05 p.m. HM-B stated she was not aware she needed to post the facility license in the main entrance of the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER AMC CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6601 75TH 1/2 AVENUE NORTH BROOKLYN PARK, MN 55428			
(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
0 630	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, 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 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: R1 R1 was admitted to the licensee's Assisted Living Facility (ALF) license on April 1, 2023. R1's diagnoses included schizophrenia (a severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal). R1's Service Plan/Care Plan dated April 1, 2023, indicated he received the service of medication administration and assistance with housekeeping and laundry. On December 19, 2023, at 8:10 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. R1's Vulnerability Assessment dated April 1, 2023, indicated the chronic illness/disability of	0 630			

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0 630	Continued From page 10 schizophrenia, and R1 was unable to manage his own finances and included the statement that indicated "mom" managed them. A box indicated "no" in reference to R1's susceptibility to abuse by others in the home. Additionally, the Vulnerability Assessment lacked interventions to minimize R1's susceptibility to abuse by others. R2 R2 was admitted to the licensee's ALF on January 10, 2023. R2's diagnoses included schizophrenia. R2's Service Plan/Care Plan dated January 10, 2023, indicated he received services to include medication administration and assistance with housekeeping and laundry. On December 19, 2023, at 10:00 a.m. ULP-D was observed to interact with R2 in the kitchen during breakfast. R2's Vulnerability Assessment dated January 10, 2023, indicated the chronic illness/disability of schizophrenia. A box indicated "no" in reference to R2's susceptibility to abuse by others in the home. Additionally, the Vulnerability Assessment lacked interventions to minimize R2's susceptibility to abuse by others. On December 18, 2023, at 3:40 p.m. clinical nurse supervisor (CNS)-C stated, "yes, they are vulnerable to abuse." The licensee's Vulnerable Adult policy dated July 30, 2021, indicated the licensee would contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults.	0 630			

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0 630	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. 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 is issued at a widespread scope (when problems	0 640			

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0 640	Continued From page 12 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 December 18, 2023, at 2:00 p.m. the surveyor observed postings on the upper/main level of the facility and noted the facility lacked the required information and phone numbers for reporting to MAARC. On December 18, 2023, at 2:05 p.m. house manager (HM)-B stated she had not realized the requirement to post this information. The licensee's Vulnerable Adult policy dated July 30, 2021, indicated contact information for MAARC shall be posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled 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;	0 650			

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0 650	Continued From page 13 (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 contained the required content for one of one employee (unlicensed personnel (ULP)-D). 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: ULP-D started employment on January 9, 2021. On December 19, 2023, at 8:15 a.m. ULP-D was observed to administer medications to R1. ULP-D's record lacked evidence of documentation of annual performance reviews that identified areas of improvement needed and	0 650			

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0 650	Continued From page 14 training needs. On December 19, 2023, at 2:28 p.m. house manager (HM)-B stated ULP-D had not had an annual performance review and added, no employees received an annual performance review. The licensee's Personnel Records policy dated July 30, 2021, noted the personnel record for each person would include at minimum, performance reviews. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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	0 660			

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0 660	Continued From page 15 by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment. This had the potential to affect all current 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 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 December 18, 2023, at 8:10 a.m. the surveyor was provided the facility's TB policy. The information provided did not include the facility's TB risk assessment. On December 20, 2023, at 10:00 a.m. clinical nurse supervisor (CNS)-C confirmed the licensee had not completed a TB risk assessment as required, and stated she would use the assessment tool provided by the Minnesota Department of Health. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment.	0 660			

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0 660	Continued From page 16 The licensee's Tuberculosis Screening/Prevention policy dated July 30, 2021, indicated the Director was responsible for conducting the formal TB Risk Assessment and updating it annually. 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; 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	0 680			

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0 680	Continued From page 17 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements and failed to post the plan prominently. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 19, 2023, at 2:45 p.m. house manager (HM)-B and the surveyor met to review the contents of the licensee's EP plan and appendix Z requirements. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - a system to track the location of on-duty staff and sheltered residents. - a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records - a policy/procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act	0 680			

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0 680	Continued From page 18 - a communication plan to include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee The licensee failed to conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP plan, failed to review and update the EP plan annually, and failed to review and update the Missing Person Policy on a quarterly basis as required. On December 19, 2023, at 3:15 p.m. HM-B stated the licensee had a consulting company help with writing the EP plan, but the EP plan still had some areas that needed more facility specific information, and the licensee had not yet participated in a training exercise to practice their plan. Additionally, HM-B stated the licensee had not reviewed the EP plan annually and stated she was not aware of the need to review the Missing Person policy on a quarterly basis. The licensee's Emergency Preparedness policy dated July 30, 2021, indicated [licensee name] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			

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0 690	Continued From page 19	0 690			
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the licensee's two resident's (R1, R2) records were authenticated by the name and title of the person making the entry. 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 the residents). The findings include: R1 R1's Home Health Aide Charting Sheet dated December 2, 2023, through December 18, 2023, included staff initials but lacked staff names/signatures and credentials/title. R1's Progress Notes dated November 27, 2023, through December 17, 2023, included handwritten note entries, each ended with staff initials. The record lacked staff name/signature and credentials/title.	0 690			

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0 690	Continued From page 20 R1's Medication Administration Record (MAR) dated December 2023, included a section for staff initials and staff signature; however, the record lacked staff credentials/titles. R2 R2's Home Health Aide Charting Sheet dated December 2, 2023, through December 18, 2023, included staff initials, but lacked staff names/signatures and credentials/title. R2's Progress Notes dated November 27, 2023, through December 17, 2023, included handwritten entries, each ended with staff initials. The record lacked staff name/signature and credentials/title. R2's MAR dated December 2023, included staff initials and staff name/signature; however, the record lacked staff credentials/titles. On December 18, 2023, at 4:10 p.m. house manager (HM)-B reviewed HHA task charting, progress notes, and MARs for R1 and R2 and stated there were only staff initials for the task sheets and progress notes and the even though the MAR included a signature section for staff, it lacked staff credentials. The licensee's Clinical Record Policy dated July 30, 2021, indicated all entries into the clinical record would be legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			

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0 730	Continued From page 21	0 730			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730			

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0 730	Continued From page 22 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to clearly indicate the services to be provided for the licensee's two residents (R1, R2), and lacked consistent documentation of services completed. Additionally, the licensee failed to ensure the resident record included a discharge summary with the required content and provided information to the receiving facility as required for one of one discharged 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, 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: DOCUMENTATION OF SERVICES R1 R1's diagnoses included schizophrenia (a severe brain disorder that affects how people perceive and interact with reality, often causing	0 730			

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0 730	Continued From page 23 hallucinations, delusions, and social withdrawal). R1's Service Plan/Care Plan dated April 1, 2023, indicated he received the service of medication administration and assistance with housekeeping and laundry. On December 19, 2023, at 8:10 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. R1's Home Health Aide Charting Sheet dated December 2, 2023, through December 18, 2023, included a template of multiple options for tasks the ULP could perform; however, the document lacked a clear indication of which tasks were assigned to R1 and when they should be performed/completed. Additionally, R1's Home Health Aide Charting Sheet lacked consistent documentation of tasks completed by the ULP. R2 R2's diagnoses included schizophrenia. R2's Service Plan/Care Plan dated January 10, 2023, indicated he received services to include medication administration and assistance with housekeeping and laundry. On December 19, 2023, at 10:00 a.m. ULP-D was observed to interact with R2 in the kitchen during breakfast. R2's Home Health Aide Charting Sheet dated December 2, 2023, through December 18, 2023, included a template of multiple options for tasks the ULP could perform; however, the document lacked a clear indication of which tasks were	0 730			

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0 730	Continued From page 24 assigned to R2 and when they should be performed/completed. Additionally, R2's Home Health Aide Charting Sheet lacked consistent documentation completed by the ULP. DISCHARGE SUMMARY R3 R3 was admitted to the assisted living facility on September 6, 2022, and discharged to another facility on March 21, 2023. R3's Service Plan was requested but was not received. R3's Discharge Summary dated March 21, 2023, indicated the following information: diagnoses, summary of services provided (medication, behavior), health status at discharge (stable, alert), medications at discharge (medications and dosages listed) disposition of medications (gave to other group home manager), reason for discharge (went to a different group home), and discharged to (went to a different group home). The record lacked the following required content: - allergies; - course of illness; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On December 19, 2023, at 11:19 a.m. house manager (HM)-B stated the staff know when tasks were to be completed, but the task records (Health Aide Charting Sheet) were unclear as to which tasks were to be completed for both	0 730			

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0 730	Continued From page 25 licensee's residents. Additionally, HM-B stated not all tasks were consistently being documented as completed by the ULP. On December 20, 2023, at 10:05 a.m. clinical nurse supervisor (CNS)-C stated she was using the licensee's formatted discharge summary and included what she knew. CNS-C stated she would review the required content for a discharge summary and develop something more in line with regulation. The licensee's Clinical Record policy dated July 30, 2021, indicated the resident record would include documentation of services provided as identified in the service plan. The licensee's Discharge and Transfer of Residents policy dated July 30, 2021, indicated the Discharge Summary would include: - courses of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. No further information provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire	0 790			

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0 790	Continued From page 26 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 current tags and documentation of annual and monthly inspections of all the fire extinguishers. Also failed to provide adequately rated portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and 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, 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: On a facility tour on December 18, 2023, at 3:26 p.m., with house manager (HM)-B, survey staff observed the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that annual and	0 790			

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0 790	Continued From page 27 monthly inspections had been performed as required. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. It was also observed the fire extinguisher in the laundry room was 1-A:10-BC (size) rated and did not have at least a 2-A:10-B:C rating fire extinguisher as required by MN Statute 144G.45. On December 18, 2023, at 3:26 p.m., HM-B verbally confirmed the lack of fire extinguisher inspections and lack of required fire extinguisher size in the facility. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
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	0 810			

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0 810	Continued From page 28 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for 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 a record review and interview, the licensee failed to conduct required evacuation drills. This 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 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 December 19, 2023, at 9:08 a.m., house manager (HM)-B provided documentation on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.	0 810			

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0 810	Continued From page 29 Record review of the available documentation indicated the licensee did evacuation drills April 6th, 2023, August 5th, 2023, and November 5th 2023 but did not doing them twice per year per shift and every other month for employees as required by statute. On December 19, 2023, at 11:30 a.m., HM-B confirmed drills were not completed as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide properly sized egress windows for resident rooms that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff.	0 820			

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0 820	Continued From page 30 This practice resulted in a level two violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: On December 18, 2023, at 1:00 p.m., survey staff conducted a facility tour with house manager (HM)-B. During facility tour, survey staff observed the following: HM-B fully opened the proposed egress window in unoccupied resident room #1 and survey staff verified the measurement of the openable area of the window to be 15.5 inches (in.) high x 26 in. wide for a total of 403 square inches. HM-B fully opened the proposed egress window in unoccupied resident room #2 and survey staff verified the measurement of the openable area of the window to be 16 in. high x 34.5 in. wide for a total of 552 square inches. HM-B fully opened the proposed egress window in unoccupied resident room #3 and survey staff verified the measurement of the openable area of the window to be 15 in. high x 34 in. wide for a total of 510 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20 in.	0 820			

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0 820	Continued From page 31 On December 18, 2023, at 1:00 p.m., HM-B verified the non-compliant egress window sizes. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950			

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0 950	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for two of two residents (R1, R2). 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 the residents). The findings include: R1 and R2's records lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R1's Assisted Living Contract dated April 1, 2023, lacked the required notice to designate a representative.	0 950			

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0 950	Continued From page 33 R2's Assisted Living Contract dated January 10, 2023, lacked the required notice to designate a representative. On December 19, 2023, at 11:25 a.m. house manager (HM)-B stated the licensee had the appropriate form for this requirement but had not implemented it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500			

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01500	Continued From page 34 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D).	01500			

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01500	Continued From page 35 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: ULP-D was hired on January 9, 2021, to provide direct care services to the licensee's residents. On December 19, 2023, at 8:15 a.m. ULP-D was observed to administer oral medications to R1. ULP-D's record lacked the required eight hours of annual training for 2022; furthermore, the record lacked the required annual training content to include: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging	01500			

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01500	Continued From page 36 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On December 19, 2023, at 2:32 p.m. house manager (HM)-B stated ULP-D's employee record lacked evidence of training for 2022, and further stated the licensee based the annual training requirement on each employee's hire date anniversary. The licensee's Staff Orientation and Education policy dated July 30, 2021, indicated all staff that perform assisted living services would complete at least eight hours of annual training for each 12 months of employment. Education topics would include, but not be limited to: - Reporting maltreatment of vulnerable adults; - Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Review of the organization's policies and procedures related to provision of assisted living services and how to implement them; - Infection control techniques used in the home; - Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - Principles of person-centered planning/service delivery.	01500			

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01500	Continued From page 37 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees	01530			

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NAME OF PROVIDER OR SUPPLIER AMC CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6601 75TH 1/2 AVENUE NORTH BROOKLYN PARK, MN 55428			
(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
01530	Continued From page 38 (unlicensed personnel (ULP)-D, ULP-E) received the required amount of dementia care training in the required time frame. 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 provided services under an Assisted Living license. ULP-D ULP-D had a hire date of January 9, 2021, and provided direct care services under the licensee's assisted living license. ULP-D's employee record contained evidence of one hour of dementia training dated January 9, 2021, and four hours of dementia training dated February 15, 2015. ULP-D's record indicated a total of five hours of dementia training but not the required eight hours of training within 160 working hours of the employment start date as required. Additionally, ULP-D's record lacked the required two hours of annual dementia training. ULP-E ULP-E had a hire date of July 28, 2023, and provided direct care services under the licensee's assisted living licensure. ULP-E's employee record contained evidence of	01530			

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01530	Continued From page 39 three hours of dementia training dated July 28, 2023, with two additional undated, dementia training certificates which indicated two hours of dementia training. ULP-E's record indicated a total of five hours of dementia training but not the required eight hours of training within 160 working hours of the employment start date as required. On December 19, 2023, at 12:19 house manager (HM)-B stated she thought the requirement for dementia training was four hours, and stated none of the current staff would have the required eight hours of dementia training at the time of hire. Furthermore, HM-B stated she was not aware ULP-D's annual dementia training requirement had not been met. The licensee's Dementia Education policy dated July 30, 2021, indicated direct care employees will complete eight hours of initial training within 160 hours of the employment start date. Additionally, the policy indicated the staff would complete two hours of education on topics related to dementia for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	01620			

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01620	Continued From page 40 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for the licensee's two current residents (R1, 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 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:	01620			

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01620	Continued From page 41 R1 R1 was admitted to the licensee under the Assisted Living Facility (ALF) license on April 1, 2023. R1's Service Plan/Care Plan dated April 1, 2023, indicated he received the service of medication administration and assistance with housekeeping and laundry. On December 19, 2023, at 8:10 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. R1's Comprehensive Assessments since date of admission were requested. R1's Comprehensive Assessments dated April 1, 2023, (admission assessment), April 13, 2023, (14-day assessment) and July 13, 2023, (90-day assessment) were provided. The licensee failed to complete further 90-day reassessments as required. R2 R2 was admitted to the licensee's ALF on January 10, 2023. R2's Service Plan/Care Plan dated January 10, 2023, indicated he received services to include medication administration and assistance with housekeeping and laundry. On December 19, 2023, at 10:00 a.m. ULP-D was observed to interact with R2 in the kitchen during breakfast. R2's Comprehensive Assessments since date of admission were requested. R2's Comprehensive Assessments dated January 1, 2023, (admission assessment), January 24, 2023, (14-day	01620			

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01620	Continued From page 42 assessment), and April 10, 2023, (90-day assessment) were provided. The licensee failed to complete further 90-day reassessments as required. On December 18, 2023, at 3:50 p.m. clinical nurse supervisor (CNS)-C stated she understood a comprehensive assessment was to be completed on the date of admission, day 14, day 90, and then with change in condition and yearly. She stated she completed both licensee residents' assessments with this understanding and did not complete a recurring every 90-day assessment after the first 90 days. The licensee's Assessment and Reassessment policy dated July 30, 2021, indicated ongoing resident reassessments must be conducted by a registered nurse and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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	01650			

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01650	Continued From page 43 providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for the licensee's two residents (R1, 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 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: R1	01650			

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01650	Continued From page 44 R1's diagnoses included schizophrenia (a severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal). R1's Service Plan/Home Health Aide Care Plan dated April 1, 2023, indicated he received the services of medication administration and assistance with housekeeping and laundry. On December 19, 2023, at 8:10 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. R2 R2's diagnoses included schizophrenia. R2's Service Plan/Home Health Aide Care Plan dated January 10, 2023, indicated he received services to include medication administration and assistance with housekeeping and laundry. On December 19, 2023, at 10:00 a.m. ULP-D was observed to interact with R2 in the kitchen during breakfast. ULP-D stated R2 received the services of daily medication management in the evening and assistance with housekeeping tasks. R1 and R2's Service Plan/Home Health Aide Care Plans lacked frequency of each service. On December 19, 2023, at 11:15 a.m. house manager (HM)-B reviewed R1 and R2's Service Plans which indicated the homemaker interventions (tasks), lacked instructions and frequency, and should have been clearer. The licensee's Service Plan policy dated July 30, 2021, indicated the service plan would include: - the fees for services and the frequency of each	01650			

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01650	Continued From page 45 service, according to the resident's current review or assessment and resident preferences No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730			

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01730	Continued From page 46 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for the licensee's two current residents (R1, 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 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: R1 R1's diagnoses included schizophrenia (a severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal).	01730			

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01730	Continued From page 47 R1's Service Plan/Care Plan dated April 1, 2023, indicated he received the service of medication administration. On December 19, 2023, at 8:10 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. R1's Medication Administration Record (MAR) dated December 2023, indicated he received three medications for constipation, three supplements, two for behavior associated with schizophrenia, and one for anxiety, R1's Medication Management Plan was dated April 1, 2023. R2 R2's diagnoses included schizophrenia. R2's Service Plan/Care Plan dated January 10, 2023, indicated he received services to include medication administration. On December 19, 2023, at 10:00 a.m. ULP-D was observed to interact with R2 in the kitchen during breakfast. ULP-D stated the staff assisted R2 with medication administration daily. R2's MAR dated December 2023, indicated he received one medication for oral secretions, one for sleep, one for agitation, one for constipation, one for mild pain/fever, and one injection (by nurse) for schizophrenia. R2's Medication Management Plan was dated January 10, 2023. R1 and R2's Medication Plans lacked the	01730			

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01730	Continued From page 48 following required content: - a description of the storage of medications based on the resident assessment and addressing resident preference, risk of diversion and instructions per manufacturer; - identification of medication management tasks to be delegated to unlicensed personnel; and - plans for staff notifying the licensed health professional when/if a problem with medication management services arises (left blank) On December 20, 2023, at 10:10 a.m. clinical nurse supervisor (CNS)-C reviewed medication plan content for R1 and R2 and stated they were missing all required content and would review the regulation to edit their template to include the required elements. The licensee's Service Plan for Medication Management dated July 30, 2021, indicated the plan would include: - a description of the storage of medications based on the resident assessment and addressing resident preference, risk of diversion and instructions per manufacturer; - identification of medication management tasks to be delegated to unlicensed personnel; and - plans for staff notifying the licensed health professional when/if a problem with medication management services arises No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	01910			

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01910	Continued From page 49 the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the required content for one of one discharged 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 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:	01910			

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01910	Continued From page 50 R3's record indicated he began receiving assisted living services on September 6, 2022, and was discharged to a group home on March 21, 2023. R3's Service Plan was requested but was not received. R3's Medication Administration Record (MAR) was requested, but not received. R3's Discharge Summary dated March 21, 2023, indicated resident discharged to a group home. The Discharge Summary indicated medications at discharge included Vitamin D3, Duloxetine 600 milligrams (mg), Symbicort, Gabapentin 600 mg, Ferrous gluconate 32 mg, mirtazapine 30 mg, phenytoin-extended release 1000 mg, buspirone 10 mg, quetiapine 300 mg, pramipexole 0.5 mg, and escitalopram (no dosage). The record indicated the disposition of medications were "Given to other group home manager". R3's Discharge Summary lacked the disposition of the medication including the prescription numbers, quantity, and to whom the medications were given. On December 20, 2023, at 10:00 a.m. clinical nurse supervisor (CNS)-C stated she had not included all the required elements of medication disposition and would create a more descriptive medication disposition summary to include the required content. The licensee's Disposition and Disposal of Medications policy dated July 30, 2021, indicated upon disposition, (licensee name) will document the following information in the clinical record: a. Name, strength, and prescription number of medication, as applicable	01910			

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(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
01910	Continued From page 51 b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2023
NAME OF PROVIDER OR SUPPLIER AMC CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6601 75TH 1/2 AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
02240	Continued From page 52 (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has not 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 the residents). The findings include:	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2023
NAME OF PROVIDER OR SUPPLIER AMC CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6601 75TH 1/2 AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
02240	Continued From page 53 R1 R1 began receiving assisted living services on April 1, 2023. R1's record indicated on April 1, 2023, R1 had received a copy of the bill of rights titled: "Minnesota Home Care Bill of Rights for Assisted Living Clients" dated 2021. R2 R2 began receiving assisted living services on January 10, 2023. R2's record indicated on January 10, 2023, R1 had received a copy of the bill of rights titled: "Minnesota Home Care Bill of Rights for Assisted Living Clients" dated 2021. R1 and R2's records lacked evidence the resident received the Bill of Rights for Assisted Living Residents dated November 8, 2022. On December 19, 2023, at 12:05 p.m. house manager (HM)-B stated she was not aware of an updated Assisted Living Bill of Rights so neither of the residents would have received it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			

Type: Full
Date: 12/19/23
Time: 10:20:00
Report: 1005231288

Food and Beverage Establishment Inspection Report

Page 1

Location:

Amc Care Inc
6601 75th 1/2 Avenue North
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0039055
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632082973
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.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

THERE WAS NO LOG ON SITE FOR RECORDING EMPLOYEE ILLNESS. BLANK ILLNESS LOG WAS LEFT ON SITE.

Comply By: 12/19/23

4-300 Equipment Numbers and Capacities

4-302.12B

**** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON SITE. DISCUSSED PROVIDING AND USING A FOOD THERMOMETER TO VERIFY COOK TEMPERATURES AND COLD HODLING TEMPERATURES.

Comply By: 12/26/23

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.

THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.

Type: Full
Date: 12/19/23
Time: 10:20:00
Report: 1005231288
Amc Care Inc

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 12/26/23

6-300 Physical Facility Numbers and Capacities

6-301.11 ** Priority 2 **

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO SOAP WAS AVAILABLE AT THE KITCHEN HANDWASHING SINK. CORRECTED ON SITE.

Comply By: 12/19/23

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS WERE AVAILABLE AT THE KITCHEN HANDWASHING SINK. CORRECTED ON SITE.

Comply By: 12/19/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

EMPLOYEE HAS A FOOD PROTECTION MANAGER CERTIFICATE ISSUED 11/5/21, BUT DOES NOT HAVE THE MN CFPM CERTIFICATE. FACT SHEET EMAILED WITH REPORT.

Comply By: 01/19/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO SIGN WAS POSTED AT THE KITCHEN HANDWASHING SINK. DESIGNATE ONE SIDE OF THE TWO BASIN SINK TO BE USED FOR HANDWASHING ONLY, AND KEEP SOAP, PAPER TOWELS, AND SIGN ON THAT SIDE. SIGN LEFT ON SITE.

Comply By: 12/19/23

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/PASTA
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Type: Full
Date: 12/19/23
Time: 10:20:00
Report: 1005231288
Amc Care Inc

Food and Beverage Establishment Inspection Report

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Process/Item: Cold Hold/CREAM

Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	4	2

INSPECTION COMPLETED WITH HOUSE MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR, DEB JACOBSON. DISCUSSED ALL ORDERS ON REPORT.

INSPECTOR LEFT A THERMOLABEL ON SITE TO BE RUN THROUGH THE DISH WASHER, AND MANAGER LATER SENT A PICTURE SHOWING THAT THE UTENSIL SURFACE TEMPERATURE WAS AT LEAST 160 DEGREES F.

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

CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, BACKSPLASH IS PAINTED BRING, AND THE CEILING HAS A POPCORN FINISH. 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 1005231288 of 12/19/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

AYAAN MOHAMOUD
HOUSE MANAGER

Signed: _____

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