Electronically Delivered

September 10, 2025

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

RE: Project Number(s) SL39403016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

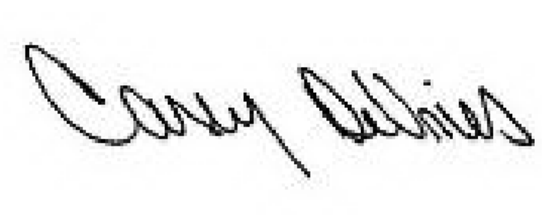
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39403	A. BUILDING: _____ B. WING _____	07/17/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39403016-0 On July 14, 2025, through July 17, 2025, 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 five residents; five receiving services under the Assisted Living Facility 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.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is	0 100		

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0 100	Continued From page 1 licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may:	0 100		

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0 100	Continued From page 2 (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when the licensee applied for licensure despite having a side by side, multi-family residence in a single building sharing one roof without having an approved two-hour fire barrier. 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: NURSE EVALUATOR (NE) On July 14, 2025, at 9:30 a.m., the Minnesota Department of Health (MDH) NE observed the licensee's facility, health facility identification (HFID) 39403, was part of a single story side by side home located at 8225 Halifax Court North,	0 100		

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0 100	Continued From page 3 Brooklyn Park, Minnesota (MN) 55443 and was attached to 8229 Halifax Court North, Brooklyn Park, MN 55443 by a shared wall; both sides had their own entrances and own garages. On July 14, 2025, at 9:38 a.m., during the entrance conference, director of operations (DO)-D stated the licensees facility was part of a side by side home which shared a wall with a rental property which did not have affiliation with the licensee. DO-D stated there was a fire inspection done when they were first opening the licensee and someone had to climb up into the attic to find out if there was a two-hour fire barrier. ENGINEER EVALUATOR (EE) TOUR Date: July 16, 2025 Time: 10:30 a.m. - 11:30 a.m. On July 16, 2025, EE observed the building was a side by side, multi-family residence. On July 16, 2025, DO-D stated they went through this same process when they obtained their provisional license, but could not provide any documentation beyond a letter from a construction company which read, "I have verified the existence of firewall separation on each side of the address above. Further, firewall is 5/8" sheet rock and all joints are with fire retardant foam." The document did not contain sufficient evidence to confirm the existence of a properly separated building. On July 21, 2025, at 3:27 p.m., DO-D sent an email to EE and NE in an attempt to provide further documentation of a sufficient two-hour separation or two-hour fire barrier. The provided document file named, "[name of construction company] 2025", did not indicate the person	0 100		

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0 100	Continued From page 4 writing the letter was a registered design professional, any information about the wall separating the two units being a listed assembly for a two-hour building separation or a two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, and did not include a drawing of the wall section and UL listed assembly for review. The provided document indicated "I have verified the existence of 1h [hour] firewall separation on each side of the address above. Further firewall is 5/8" sheet rock and all joints are with 1 hour fire retardant foam which makes it 2hous {sic} retardant all together." Statute Language: 144G.10 subd.1 (c). (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		

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0 480	Continued From page 5	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 6 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 14, 2025, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 7 Report was provided to the licensee on July 15, 2025. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control	0 500		

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0 500	Continued From page 8 and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required for nursing assessments. 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 July 14, 2025, at 9:38 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they conducted an admission assessment, 14-day assessment, 90-day assessment and then a change of condition (COC) assessment thereafter. On July 18, 2025, at 10:50 a.m., via email, the	0 500		

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0 500	Continued From page 9 surveyor requested a policy and procedure for their nursing assessment schedule and 90-day assessments. On July 21, 2025, at 12:03 p.m., DO-D responded to the surveyor's email request for policies and procedures addressing nursing assessments. DO-D's email indicated, "FYI: -nursing assessment schedule addressing 90 day assessments. (During the Survey we gave you the Nurse assessment notes for 14 & 90 days & the IAPP, that we found out was not the correct form." A policy addressing nursing assessments was not provided. The licensee failed to provide the following policies and procedures related to current assisted living assessment requirements under 144G.70 subdivision 2. - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
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	0 550		

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0 550	Continued From page 10 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 information directing individuals to the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH) if they had complaints about the facility or person providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 14, 2025, at 10:00 a.m., during the facility tour with operations director (OD)-D, the surveyor observed the licensee's postings. The grievance posting lacked information directing individuals to the OHFC if they had complaints about the facility or person providing services. OD-D stated they	0 550		

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0 550	Continued From page 11 did not know what OHFC was and wrote it down so they could add it to their postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee	0 650		

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	39403	A. BUILDING: _____ B. WING _____	07/17/2025

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

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0 650	Continued From page 12 records included a registered nurse (RN) 30-day supervision of delegated tasks for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on March 12, 2024, to provide direct cares to residents. ULP-B's employee record included a 30-day Employee Performance Review Form dated April 30, 2024, for review period of March 12, 2024, to April 30, 2024. The form lacked identification of delegated tasks supervised. The topics addressed were customer focus, mission and values, staff development, performance management, employee engagement, wellness, quality improvement, communication, professional development, financial stewardship, and job knowledge. ULP-C ULP-C was hired on February 29, 2024, to provide direct cares to residents. ULP-C's employee record included a 30-day Employee Performance Review Form dated March 31, 2024, for review period of February 29, 2024, to March 31, 2024. The form lacked	0 650		

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0 650	Continued From page 13 identification of delegated tasks supervised. The topics addressed were customer focus, mission and values, staff development, performance management, employee engagement, wellness, quality improvement, communication, professional development, financial stewardship, and job knowledge. On July 14-15, 2025, the surveyor observed ULP-B provide services to residents including engaging with residents in activities, oxygen assistance, medication administration, and meal preparation. On July 15, 2025, at 11:05 a.m., operations director (OD)-D stated they were conducting RN 30-day supervisions for their ULPs and had provided the above-mentioned forms. The surveyor explained the forms did not include what delegated tasks were supervised. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were conducting RN 30-day supervisions, but the problem was they were not documenting the supervisions, they were only using the above-mentioned form. ULP-B stated LALD/CNS-A did conduct a supervision of them performing delegated tasks. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated November 1, 2022, indicated: "1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance. 2. This requirement also applies to staff that have not performed delegated tasks for one (1) year or longer.	0 650		

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0 650	Continued From page 14 3. The supervision should be through the direct and indirect observation of the unlicensed personnel performing the services. The resident or resident's responsible person may be interviewed to assure they are satisfied with the services they are receiving. 4. It is the responsibility of the RN staff to ensure the supervision is done within the time frames outlined above and specified on the client's service plan. 5. Documentation of supervision activities will be retained in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 15 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content for staff, residents, and visitors to view. Further, the licensee failed to keep the EPP available at the facility. 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 July 14, 2025, at 10:43 a.m., the surveyor requested the EPP. Director of operations (DO)-D stated it was stored at the office and they would bring it tomorrow (July 15, 2025). On July 15, 2025, at 12:11 p.m., the surveyor completed review of the licensee's Emergency Preparedness Operations Plan which was undated. The EPP lacked evidence of the following: - reviewed and updated annually;	0 680		

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0 680	Continued From page 16 - all-hazards risk assessment; - missing resident policy review every three months; - identified evacuation transportation; - identified evacuation location contract/agreement; - include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - minimum food, water, and pharmaceutical supplies stored onsite; - communication plan must include contact information for the following: - federal, state, tribal, regional & local EP staff. On July 15, 2025, at 12:11 p.m., the surveyor explained the licensee's EPP lacked an all-hazards risk assessment and only listed their top five risks; DO-D asked what was required of the all-hazards risk assessment and the surveyor explained it to them. DO-D stated emergency supplies were not onsite, they had no evacuation agreements with their selected evacuation locations and no transportation plans other than to call 911. DO-D stated the EPP was stored at the office but was normally kept onsite. The licensee's Emergency Preparedness Operations Plan, undated, indicated: is committed to protecting the well-being of our residents, staff and visitors. An important aspect of this responsibility is the development and active commitment of facility leadership and staff to an effective Emergency. This documents our facility's All-Risk Emergency Preparedness Operations Plan states how we will manage and conduct actions under emergency conditions. We understand that there are a variety of hazards, both natural and human-caused, that	0 680		

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0 680	Continued From page 17 may pose risks to the health and safety of residents, staff and visitors. Furthermore, these hazards may also pose risks to our on-going business operations. We recognize that the effectiveness of this plan requires the commitment of facility administrators and staff. This plan will be reviewed at annually and updated as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 18 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 16, 2025, director of operations (DO)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety & Evacuation	0 810		

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0 810	Continued From page 19 Plan, dated October 27, 2024, failed to include the following: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On July 16, 2025, at 11:30 a.m., DO-D stated they didn't have any resident specific procedures, but would work on developing them. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia, menta All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two hours of initial mental illness and de-escalation training were conducted within 160 hours of providing direct care to residents for two of two direct care	01490		

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01490	Continued From page 20 staff (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on March 12, 2024, to provide direct cares to residents. ULP-C ULP-C was hired on February 29, 2024, to provide direct cares to residents. ULP-B and ULP-C's employee records lacked documentation of mental illness and de-escalation training. On July 14-15, 2025, the surveyor observed ULP-B provide services to residents including engaging with residents in activities, oxygen assistance, medication administration, and meal preparation. On July 15, 2025, at 10:49 a.m., director of operations (DO)-D and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not know about the new regulation requirement for mental illness and de-escalation training. DO-D questioned when the new requirement began, and the surveyor explained the new requirement began on July 1, 2025.	01490		

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01490	Continued From page 21 On July 21, 2025, at 12:03 p.m., DO-D responded to the surveyor'ss email request for policies and procedures for mental illness and de-escalation training. DO-D's email indicated, "FYI: mental health de-escalation training----We did NOT have the forms from Care Providers at the time of Survey. I have received them now going forward." A policy addressing the training was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services;	01620		

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01620	Continued From page 22 (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment 14 days after admission and no longer than 90 days thereafter for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01620		

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01620	Continued From page 23 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on March 21, 2023. R2's Service Plan Form dated April 4, 2023, indicated R2 received services for dressing, grooming, toileting, medication management, and transfers. R2's record included an admission Uniform Assessment Tool Form completed on March 21, 2023. A 14-day assessment was completed on a Nurse Progress Notes form on April 6, 2023, 16 days after the admission assessment. A 90-day assessment was completed on a Nurse Progress Notes form on June 21, 2023. R2's record lacked further 90-day assessments. On July 14, 2025, at 9:38 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they conducted an admission assessment, 14-day assessment, 90-day assessment and then a change of condition (COC) assessment thereafter. On July 14, 2025, at 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and director of operations (DO)-D both stated 90-day assessments were not conducted past the first one completed on June 21, 2023. Both stated it was their understanding they were only required to completed one 90-day assessment after the 14-day assessment and did	01620		

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01620	Continued From page 24 not require further assessments unless there were a change in condition (COC). On July 15, 2025, at 10:15 a.m., LALD/CNS-A and DO-D had further questions about the 90-day assessment process; both stated they though it was the individualized abuse prevention plan (IAPP) which was required to be completed every 90 days. The surveyor explained a comprehensive nursing assessment was required to be completed every 90 days, not the IAPP. On July 21, 2025, at 12:03 p.m., DO-D responded to the surveyor's email request for policies and procedures for nursing assessments. DO-D's email indicated, "FYI: -nursing assessment schedule addressing 90 day assessments. (During the Survey we gave you the Nurse assessment notes for 14 & 90 days & the IAPP, that we found out was not the correct form." A policy on nursing assessments was not provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Always Amazing Home Care LLC
8225 Halifax Court
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: 0040069

Risk:
License: -1
Expires on: 12/31/2022
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1047251068
Inspection Type: Full - Single
Date: 7/14/2025 Time: 10:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
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.
COMMENT: NO PAPERTOWEL AT HANDWASHING SINK. CORRECTED ON SITE- PAPERTOWEL AT SINK WAS RESTOCKED DURING INSPECTION
Comply By: Complied On Site Originally Issued On: 7/14/2025

Food & Beverage General Comment

Inspection conducted with operator and MDH Nurse Evaluator J. Keen.

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

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

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1047251068 from 7/14/2025

Tricia Vasquez
Operating Director

Holly Sievers,
Public Health Sanitarian 2
651-201-5946
holly.sievers@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Always Amazing Home Care LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1047251068
Inspection Type: Full
Date: 7/14/2025
Time: 10:00 am

Equipment Temperature: Product/Item/Unit: Ambient**; Temperature Process:** Ambient Air
Location: Garage Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ham**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

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St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Always Amazing Home Care LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1047251068
Inspection Type: Full
Date: 7/14/2025
Time: 10:00 am

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Sanitizer Bucket
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No