Electronically Delivered

May 17, 2024

Licensee
Empathy Home Care Inc.
7333 Kentucky Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL34730015

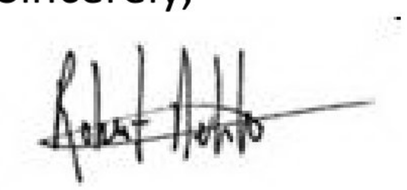
Dear Licensee:

On May 6, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 18, 2024, 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,



Bob Dehler, Engineering Manager
Engineering Services Section
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34730	A. BUILDING: _____ B. WING _____	R 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPATHY HOME CARE INC	7333 KENTUCKY 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: SL34730015-1 On May 6, 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 January 18, 2024. At the time of the survey, there were 4, residents; all receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{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 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	{0 100}		

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{0 100}	Continued From page 1 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). (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: (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: No further action needed.	{0 100}		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services	{0 110}		

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{0 110}	Continued From page 2 and Supports. This MN Requirement is not met as evidenced by: No further action needed.	{0 110}		
{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 action needed.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}		

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{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 action needed.	{0 640}		
{0 650} SS=D	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 reviews that identify areas of improvement	{0 650}		

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{0 650}	Continued From page 4 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 action needed.	{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 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 5 requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The 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	{0 810}		

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{0 810}	Continued From page 6 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action needed.	{0 810}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action needed.	{0 970}		
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under	{01290}		

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{01290}	Continued From page 7 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action needed.	{01290}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action needed.	{01760}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced	{01880}		

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{01880}	Continued From page 8 by: No further action needed.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action needed.	{01890}		

Electronically Delivered

April 4, 2024

Licensee
Empathy Home Care Inc
7333 Kentucky Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL34730015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or

financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

HHH

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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: SL34730015-0 On January 16, 2024, through January 18, 2024, 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 four residents, all of whom received 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.	
0 100 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). (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: (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.	0 100		

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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
0 100	Continued From page 2 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 two licensures despite having a single building sharing one roof without having an approved two-hour fire wall. 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: The licensee's health facility identification (HFID) 34730 was located at 7333 Kentucky Avenue North Brooklyn Park Minnesota (MN) 55438 (facility one) and was attached to 7325 Kentucky Avenue North Brooklyn Park MN 55428 (facility two) with HFID 34731 by a shared wall as a side-by-side twin home. On January 17, 2024, at 10:45 a.m., during a facility tour the Minnesota department of Health (MDH) environmental engineer (EE) surveyor observed through the attic access of facility number one and facility number two that drywall extended through the attic attached to the roof trusses from the top of wall separating facility number one and facility number two to the roof deck. Survey staff was unable to verify if the drywall extending through the attic to the roof deck was part of a continuous two-hour fire wall.	0 100		

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	34730	A. BUILDING: _____ B. WING _____	01/18/2024

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0 100	Continued From page 3 On January 17, 2024, at 11:00 a.m., the MDH EE surveyor observed the separating wall between facility number one and facility number two on the main floor in order to verify the wall was a two-hour continuous fire wall. Survey staff was unable to verify the wall separating facility number one and facility number two was a continuous two-hour fire wall. On January 17, 2024, at 11:15 a.m., the MDH EE surveyor observed the portion of the floor system below the wall separating facility number one and facility number two. Survey staff observed through the floor joist cavity no drywall was installed and the wood rim joist of the floor system was visible between facility number one and facility number two. Survey staff was unable to verify the area in the floor system below the wall separating facility number one and facility number two was part of a continuous two-hour fire wall. On January 17, 2024, at 11:30 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they could not verify if the wall separating facility number one and facility number two within the same building was a continuous two-hour fire wall. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 100		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 4 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 of the residents). These findings include: On January 18, 2024, at 8:31 a.m., the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS) website which indicated the clinical nurse supervisor/living assisted living director (CNS/LALD)-C held a current assisted living director license, however, was not listed as the director of record for the licensee. On January 18, 2024, at 10:30 a.m., CNS/LALD-C stated they tried to register as the director of record on BELTSS however, was unable to complete due to complications with entering information. CNS/LALD-C indicated they attempted to contact BELTTS during survey and	0 110		

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0 110	Continued From page 5 stated, "I called them, and they said it will be up to two days before they get back to me, but I went online to try to fix it but it wouldn't let me, but I have the required license and it doesn't expire until this year in October and it is active in the system." No further information was received. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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: 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:	0 480		

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0 480	Continued From page 6 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 17, 2024, 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		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observations, interview, and record review, the facility failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control hand hygiene, for all of the 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	0 510		

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0 510	Continued From page 7 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 January 16, 2024, at 1:15 p.m., the surveyor observed there to be no hand towels in the basement bathroom for drying hands after hand hygiene was performed. On January 17, 2024, at 11:00 a.m., the surveyor observed the basement bathroom that was utilized by staff, residents, and visitors to have no hand towels for drying hands after hand hygiene was performed. The surveyor observed two different residents utilize the bathroom prior. The surveyor requested towels be placed in the bathroom, and unlicensed personnel (ULP)-B brought a roll of paper towels and placed them in the bathroom. ULP-B stated, "The residents do have towels in their rooms they can use." On January 17, 2024, at 12:24 p.m., clinical nurse supervisor/living assisted living director (CNS/LALD)-C stated, "When they [residents and staff] wash their hands, they use paper towel and dry their hands and use the paper towel to turn off the faucet. If there are no towels, they need to inform someone." The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers guidance dated January 30, 2020, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and	0 510		

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0 510	Continued From page 8 when hands were visibly soiled. The licensee's 8.09 Hand washing policy dated January 12, 2023, read, "Proper hand washing techniques should be used to protect the spread of infection. Steps: 1. Stand away from the sink. Hands and sleeves must not touch the sink 2. Turn on water and adjust to a comfortably warm temperature 3. Wet hands and wrists 4. Apply soap over hands and wrists, working into a generous lather by scrubbing vigorously 5. Use friction and scrub vigorously for at least 20 seconds (long enough to sing 'Happy Birthday' twice) 6. Be sure to clean beneath the fingernails, around the knuckles and along the sides of the fingers and hands 7. Rinse hands and wrists completely under running water to wash away suds and microorganisms 8. DO NOT TURN FAUCETS OFF WITH CLEAN HANDS - see #10 below 9. Pat hands and wrists dry with a paper towel. It is unacceptable to use client towels for drying hands 10. Turn off water using a clean paper towel to prevent recontamination of the hands 11. If leaving a washroom/restroom, use paper towels to grasp door handle upon exit to prevent recontamination of clean hands" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 640	Continued From page 9	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: Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 16, 2024, at 9:55 a.m., the surveyor observed no 911 emergency number posted near	0 640		

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0 640	Continued From page 10 the cordless telephone in the living room. Unlicensed personnel (ULP)-B stated staff and residents used the cordless telephone. On January 18, 2024, at 10:45 a.m., clinical nurse supervisor/living assisted living director (CNS/LALD)-C stated residents used the cordless telephones, and the 911 emergency number was posted on the kitchen refrigerator and a located in a staff binder. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	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 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	0 650		

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0 650	Continued From page 11 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 interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired June 3, 2019, to provide direct cares and services to residents. ULP-B's record lacked orientation to assisted living regulations, Minnesota Statute, chapter 144G.63, subdivision 2 to include the following: -overview of assisted living statutes. On January 18, 2024, at 7:30 a.m., ULP-B stated, "I did all that training when all the rules changed for assisted living, [CNS/LALD-C] did that training for us." On January 18, 2024, at 10:48 a.m., CNS/LALD-C stated when the licensee converted from a comprehensive home care license to an assisted living license all employees received	0 650		

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0 650	Continued From page 12 orientation related to assisted living by watching videos and attending a in person training in August of 2021. CNS/LALD-C stated they documented the orientation, however, were unable to find the documents. The licensee's 5.10 Training Record policy dated August 21, 2021, read, "Empathy Home Care Inc. will document the following information for each competency evaluation, training, retraining, and orientation topic: 1. Facility name, location, and license number 2. Name of the training topic or training program 3. The training methodology, such as classroom style, web-based training, video, or one-to-one training 4. Date of the training and the competency evaluation, and the total amount of time of the training and competency evaluation 5. Name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation, and 6. Name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. 7. Documentation of the completed competency evaluation, training, retraining, or orientation will be provided to the employee at the time the evaluation or training is completed." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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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 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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	0 680		

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0 680	Continued From page 14 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's emergency disaster preparedness plan lacked evidence of the following required content: - Annual review; - Risk assessment that considered hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - Categorize the various probable risks/hazards by likelihood of occurrence; - Strategies for addressing facility & community-based risks; - Quarterly review of missing resident policy; - Emergency prep testing requirements that include: - Conducting exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: - Participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and	0 680		

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0 680	Continued From page 15 - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise plan as needed. On January 18, 2024, at 11:03 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated the EPP was last updated in 2022. In addition, CNS/LALD-C stated they did not have documentation of an annual full-scale exercise that was community based or conduct an annual, individual or facility-based functional exercise. CNS/LALD-C stated they would look for the documentation and send it to the surveyor if they located the document. The surveyor did not receive the documentation listed above upon exiting the facility. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's EPP would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 16 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. 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 the potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 17, 2024, at 9:45 a.m., with clinical nurse supervisor/licensed	0 780		

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0 780	Continued From page 17 assisted living director (CNS/LALD)-C, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the dwelling unit. During the tour CNS/LALD-C operated the test button on the hardwired alarm in the main floor corridor and it did not activate all alarms throughout the facility it only activated that alarm. It was also observed on the same tour, the hardwired smoke alarm in the living room in the basement was missing with exposed electrical wires in the electrical box. All existing smoke alarms that are hardwired and receive power from the building electrical system are required to remain hardwired. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and CNS/LALD-C, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. During the tour CNS/LALD-C also stated they did not know existing smoke alarms were required to continue to be hardwired and receive power from the building electrical system when installed as hardwired at time of construction. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 18 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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, 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). Findings include: On a facility tour on January 17, 2024, at 10:00 a.m., with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C, the surveyor made the following observations of facility hazards and disrepair: There were 2-12 inch by 12 inch holes in the wall exposing insulation above the bed in resident room number 2 occupied by R4.	0 800		

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0 800	Continued From page 19 There was daisy chained (connected in a series) power strips in resident room number 2 occupied by R4. Power strips are required to be used according to the manufacture's instructions, plugged directly into the wall outlet, and not have other power strips plugged into them in accordance with Minnesota Fire Code in Minnesota Rules, chapter 7511. There were holes in the fire-resistant wall between the attached garage and the adjacent house number 2 attached garage and between the attached house number 1 garage and house number 1. The drywall wallcovering of fire-resistant walls is required to be maintained as approved at the time of construction without penetrations or holes and sealed to prevent the passage of smoke or fire from one side of the wall to the other according to Minnesota Fire Code in Minnesota Rules, chapter 7511. The trim was broken, causing a trip hazard and sharp edges in the middle of the kitchen floor between the kitchen and living room. The crank handle used to open the window was missing from the emergency escape and rescue window opening in resident room number 4 occupied by R3. Resident room emergency escape and rescue window openings are required to be maintained in operating condition in order to be used immediately in the event of a fire or similar emergency according to Minnesota Fire Code in Minnesota Rules, chapter 7511. A new crank handle was installed on the window while survey staff was on-site. The exterior storm door would not close as designed because the closer arm and other hardware was bent on the outside of the main	0 800		

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0 800	Continued From page 20 front exit door. The light fixture globe was missing from the light fixture in the main floor bathroom and the basement living room. Light fixtures are required to be maintained with all protective covers as approved at the time of construction according to manufactures instructions and Minnesota Fire Code in Minnesota Rules, chapter 7511. The bottom step rise measured 12 inches high on the exterior stairs leading up to the main exit door. Individual step height is required to be equal to the remaining stairs in the stairway according to Minnesota Fire Code in Minnesota Rules, chapter 7511. The soffit board adjacent to the roof is coming loose on the exterior creating a hole to the attic left and above of the main exit door. A metal container was observed near the exterior landing at the door leading outside from the kitchen. It was observed there were no discarded cigarette butts in the metal container. Used smoking materials are required to be discarded in a metal container in accordance with Minnesota Fire Code in Minnesota Rules, chapter 7511. During an interview on January 17, 2024, at 11:20 a.m., CNS/LALD-C, stated there were cigarette butts on the ground around the front door exterior landing and there were no cigarette butts in the metal container by the kitchen door exterior landing because it had just been dumped the day before. It was also stated by CNS/LALD-C that the exterior landing for the kitchen door is the designated smoking area according to the facility smoking policy. During a facility tour on January 17, 2024, at	0 800		

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0 800	Continued From page 21 11:00 a.m., CNS/LALD-C verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The 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	0 810		

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0 810	Continued From page 22 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 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 January 17, 2024, at 9:15 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C, 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 FSEP dated November 14, 2023, failed to include the following: The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs	0 810		

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0 810	Continued From page 23 of residents. The plan failed to include unique and unusual needs for evacuation for each individual resident of the facility. During an interview on January 17, 2024, at 9:30 a.m., CNS/LALD-C, stated the unique and unusual needs for each individual resident for evacuation where not included in the fire safety plan and readily available for use in the event of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. 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	0 970		

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0 970	Continued From page 24 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Assisted Living Contract included the following section which contained language waving the licensee's liability for health, safety, or personal property of a resident: Page 11: Miscellaneous Provisions section 1 1."The resident hereby releases Empathy Home Care from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of Empathy Home Care or its employees or agents." On January 18, 2024, at 10:50 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated the licensee used the contract listed above for all residents. CNS/LALD-C stated they were aware of the statute and updated and reissued new contracts to the residents in November 2023 when they revised the contract to remove language waving the licensee's liability. CNS/LALD-C stated they believed they had removed all the language, however, must have missed one section. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=D	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 25 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of two employees (unlicensed personnel (ULP-B)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on February 28, 2022, to	01290		

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01290	Continued From page 26 perform direct care services to the licensee's residents. On January 17, 2023, at 6:45 a.m., the surveyor observed ULP-D working for the licensee and doing shift change with ULP-B. ULP-D's employee record contained a background study dated February 28, 2022, affiliated with another of the licensee's assisted living facility under HFID 34731. ULP-D's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living HFID license 34730, effective August 1, 2021. On January 18, 2023, at 10:29 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "For [ULP-D] that was an error because he is [working in] this house only. I will need to get that fixed right away." The licensee's 4.02 Background Studies policy dated August 21, 2021, read, "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 27 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R1) with insulin administration observed during medication administration. 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 was admitted to the licensee and started receiving assisted living services June 11, 2022. R1's Service Plan dated August 29, 2023,	01760		

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01760	Continued From page 28 indicated R1 received medication administration. R1's diagnoses included renal failure, hypertension, epilepsy, glaucoma, diabetes type 2, hepatitis B, and benign prostatic hyperplasia (enlarged prostrate) R1's provider order dated August 11, 2023, included Novolog Aspart (an injectable medication for diabetes) 10 units daily. On January 17, 2024, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-B draw up R1's 10 units of insulin and administer the insulin. ULP-B failed to prime the insulin pen with two units and waste the two units prior to drawing up the 10 units of insulin. The manufacturer's instruction for Novolog Aspart dated February 2015 instructed to prime the pen before each injection, by dialing a test dose of two units, tapping the cartridge holder gently to collect air bubbles at the top, and pushing the injection button all the way in and check to see that insulin comes out of the needle and the dial returns to zero. On January 17, 2024, ULP-B stated, "I prime it when I first open a new pen but am I supposed to do it every time I use the pen? I only thought I was supposed to do it the first time we use the pen." On January 17, 2024, at 12:24 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "We have them prime the pen when it is first used, but I did not know they were not primed each time, I will re-train on that." No further information was provided.	01760		

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01760	Continued From page 29 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 16, 2024, at 9:42 a.m., the surveyor observed the kitchen refrigerator held two Lantus Solostar 100 unit (u) / milliliter (ml) NovoLog 100 u / ml insulin pens for R1. The surveyor observed one staff and two residents in the area. On January 16, 2024, at 9:45 a.m., the surveyor	01880		

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EMPATHY HOME CARE INC	7333 KENTUCKY AVENUE NORTH BROOKLYN PARK, MN 55428

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01880	Continued From page 30 observed the medication cabinet located in an alcove next to the front door to be unlocked, with one staff and two residents in the area. When the surveyor asked unlicensed personnel (ULP)-B to lock the medication cabinet, ULP-B stated, "I unlocked it this morning to get medications out and I can't get it to lock again so I will have to let [CNS/LALD] know." On January 16, 2024, at 11:30 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "I didn't realize the refrigerated medications would need to be kept in a locked box, but I think we have an extra one or I can go buy one and we will get that set up today. As for the medication cabinet, we are getting it looked at and fixed because we can't get I to lock right now." The licensee's 7.11 Medication Storage policy dated 2022, read, "Medications will be stored consistent with each residents' medication management plan and service plan. Medications managed by Empathy Home Care will be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. Medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup." Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34730	A. BUILDING: _____ B. WING _____	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPATHY HOME CARE INC	7333 KENTUCKY 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
01880	Continued From page 31 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were properly labeled for one of one residents (R1). 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: On January 16, 2024, 8:28 a.m., the surveyor observed the facility kitchen refrigerator and observed one Novolog Aspart injectable pen (an injectable medication for diabetes) to be unlabeled. Unlicensed personnel (ULP)-B stated	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34730	A. BUILDING: _____ B. WING _____	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPATHY HOME CARE INC	7333 KENTUCKY 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
01890	Continued From page 32 the insulin was for R1 and they knew it belonged to R1 because nobody else at the facility had insulin. On January 17, 2024, at 12:24 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "The one not labeled is the one he [R1] takes out to dialysis, the rest are labeled." The licensee's 7.13 Medications - Prescription Drugs & Prohibition dated August 1, 2021, read, "When [Licensee] receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *01/17/24*
Time: 10:13:50
Report: 1023241012

Food and Beverage Establishment Inspection Report

Location:
Empathy Home Care Inc
7333 Kentucky Avenue North
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0037906
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122162485
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114A ***** Priority 1 *****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

USE APPROVED SANITIZER SUCH AS UNSCENTED BLEACH FOR FOOD CONTACT SURFACES.

Comply By: 01/17/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISH WASHER BROKEN. REPAIR/REPLACE THE DISH WASHER TO BE ANSI 184 COMPLIANT.

Comply By: 01/17/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: DISH WASHER BROKEN
Violation Issued: Yes

Food and Equipment Temperatures

Type: Full
Date: *01/17/24*
Time: 10:13:50
Report: 1023241012
Empathy Home Care Inc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

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 1023241012 of 01/17/24.

Certified Food Protection Manager: FATOU JALLOW

Certification Number: 107956 Expires: 08/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
FATOU JALLOW
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us