



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 3, 2026

Licensee

Empire Systems Home Care

6012 York Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL34526016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 30, 2026, 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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. 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>

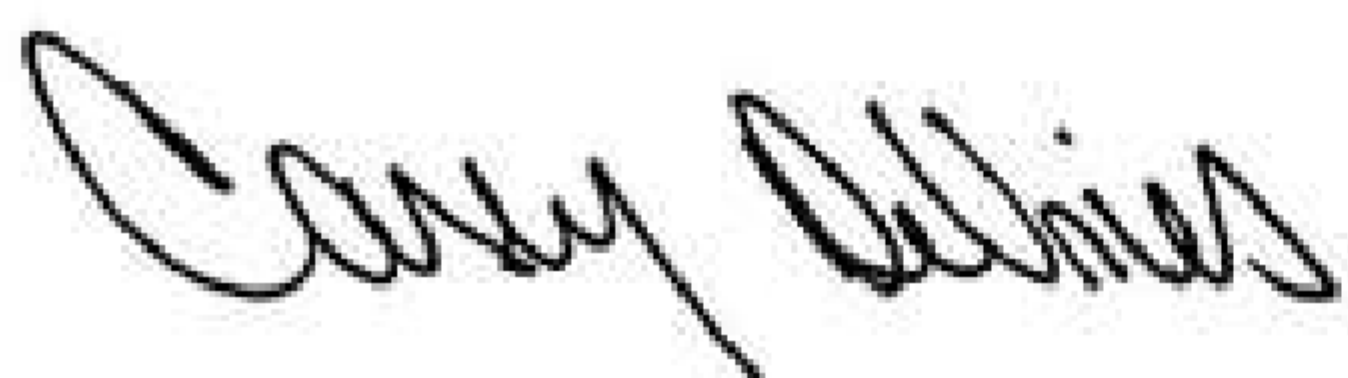
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" written in a larger, more prominent script than the last name "DeVries".

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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: SL34526016-0 On April 27, 2026, through April 30, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. 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 SUBDIVISION 1-3.		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute their plan of correction (POC) as a result of their previous routine and follow up surveys conducted on February 29, 2024, and April 17, 2024, respectively. 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	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 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 received their correction orders via electronic delivery on May 2, 2024, following their April 17, 2024, survey. The longest period for correction on the correction orders from the date of receipt was 21-days. MN Statute 144G.30 Subd. 5 (c) (1) indicates by the correction order date; the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon complaint investigation, and as otherwise needed. On April 27, 2026, through April 30, 2026, the Minnesota Department of Health conducted a routine survey and re-issued correction orders related to the following: the licensee failed to develop and implement a written staffing plan, Minnesota Food Code, menu prepared at least one week, infection control program, maintain a tuberculosis (TB) prevention and control program, written emergency preparedness plan, smoke alarms that functioned, physical environment, fire safety and evacuation plan, training and competency evaluations, direct supervision of staff, annual training, dementia care training, ongoing resident assessment and reassessment, and documentation of medication administration. The licensee's POC dated March 10, 2024, indicated the licensee had made corrections and put systems in place to mitigate all the identified issues.	0 340			

Minnesota Department of Health

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0 340	Continued From page 3 On April 29, 2026, at 2:10 p.m., administrator (A)-D stated they followed their plan of correction; however, their previous registered nurse (RN) had dropped the ball at some point. A-D also stated they had realized their non-compliance and employed a new RN to help them get back to compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable	0 470			

Minnesota Department of Health

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0 470	Continued From page 4 amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan that included an evaluation to be conducted at least twice a year, of the appropriateness of staffing levels in the 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 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 April 27, 2026, at 10:40 a.m., during the entrance conference, the surveyor requested to review the licensee's staffing plan. Clinical nurse supervisor (CNS)-A stated their staffing schedule was posted. On April 27, 2026, at 10:55 a.m., the surveyor observed the licensee's posted documents; the staffing plan was missing. On April 27, 2026, at 1:00 p.m., via email	0 470			

Minnesota Department of Health

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0 470	Continued From page 5 administrator (A)-D sent the surveyor a document and indicated on the subject line it was the licensee's staffing plan. The licensee's Staffing Management and Contingency Staffing Plan document was not dated and signed by the CNS. On April 28, 2026, at 9:00 a.m., CNS-A stated they just started working with the licensee two weeks ago. CNS-A also stated they thought the previous CNS should have completed the staffing plan. The licensee's undated Staffing & Scheduling policy indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven-days a week. Minnesota Administrative Rule Chapter 4659.0180 Subpart 3. indicated a clinical nurse supervisor must develop and implement a written staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
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	0 480			

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0 480	Continued From page 6 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; (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	0 480			

Minnesota Department of Health

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0 480	Continued From page 7 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 April 27, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485			

Minnesota Department of Health

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0 485	Continued From page 8 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a menu a week in advance and inform residents in advance of menu changes. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents 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 the potential to affect a large portion or all the residents). The findings include: On April 27, 2026, at 10:58 a.m., the surveyor observed no menu was posted in the facility. Unlicensed personnel (ULP)-B stated a menu was not posted in the facility.	0 485			

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0 485	Continued From page 9 On April 27, 2026, at 11:14 a.m., R2 stated they had never been provided with a menu and had never seen one posted in the facility. R2 stated they (staff) asked him what he wanted, and they would make the food. R2 stated sometimes they bought their own meals. On April 27, 2026, at 12:36 p.m., manager (M)-B stated they did have a menu but didn't know what happened to it. M-B stated they were aware of the requirement. The licensee's Meal and Menu Requirements policy, undated, indicated, "menus are prepared at least one week in advance and made available to all residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
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.	0 510			

Minnesota Department of Health

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0 510	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, 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 the potential to affect a large portion or all of the residents). The findings include: On April 27, 2026, at 12:40 p.m., the surveyor requested to review the licensee's infection prevention and control program. Administrator (A)-D provided the surveyor with the licensee's infection control policy. The licensee lacked an infection control program with the following content: - demonstration of leadership support; - education and training; - resident, family, and visitor education; and - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. On April 27, 2026, at 2:00 p.m., A-D stated they were unaware of the written infection control program requirement.	0 510			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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
0 510	Continued From page 11 The licensee's undated Infection Control policy indicated infection control practices are important to [licensee] for the health and safety of both staff, residents, and guests. The facility has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated Core Practices should be implemented in all settings where healthcare is delivered including: - leadership support; - education and training on infection prevention; - resident, family and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the	0 630			

Minnesota Department of Health

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0 630	Continued From page 12 abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R3 was admitted to the licensee on March 20, 2026. R3's diagnoses included undifferentiated schizophrenia, paranoid schizophrenia, and uncomplicated bipolar disorder. R3's undated Service Plan - Addendum to Contract indicated R3 received the following services: dressing, laundry, managing behavior, bathing reminder, bedmaking, and deep room cleaning. R3's Individual Abuse Prevention Plan dated April 28, 2026, during the survey, indicated R3 had no known risk to abuse themselves, difficulty weighing advice - has impaired judgment, and drinks moderately or occasionally. R3's IAPP lacked an assessment of R3's risk of being abused by others, risk for abusing other	0 630			

Minnesota Department of Health

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0 630	Continued From page 13 vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to R3 and other vulnerable adults. On April 28, 2026, at 12:50 p.m., clinical nurse supervisor (CNS)-A stated they had completed R3's IAPP and that they thought the IAPP had all the required content. The licensee's undated Vulnerable Adult policy indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. The policy indicated the plan would include the following: - an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults; - the risk of abusing other vulnerable adults; - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults; - the plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary; and - documentation will include results of the implementation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640			

Minnesota Department of Health

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0 640	Continued From page 14 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 27, 2026, at 10:56 a.m., during a facility tour, the surveyor did not observe information or a reporting number for MAARC posted in the common areas of the facility. On April 27, 2026, at 11:26 a.m., manager (M)-B stated they believed they had posted the MAARC information in the common area however, they	0 640			

Minnesota Department of Health

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0 640	Continued From page 15 were unable to locate it. M-B stated, "Sorry it is not here, but I have it on my phone." The licensee's 2.44 undated Vulnerable Adult Maltreatment - Prevention & Reporting policy, indicated the licensee would post information and the reporting number for MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by	0 660			

Minnesota Department of Health

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0 660	Continued From page 16 the Centers for Disease Control and Prevention (CDC), which included TB history and symptom screen and baseline screening for three of three employees (manager (M)-B, unlicensed personnel (ULP)-C, ULP-E). 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 the potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment dated June 27, 2024, indicated the facility was at a low risk for TB transmission. The licensee failed to complete their TB facility risk assessment annually. M-B M-B started employment with the licensee on May 18, 2018, under the former comprehensive license and started to provide assisted living services on August 1, 2021. ULP-C ULP-C started employment with the licensee on March 2, 2023, to provide assisted living services. On April 29, 2026, the surveyor observed ULP-C administer medications to R2 and R3. ULP-E ULP-E started employment with the licensee on August 13, 2025, to provide assisted living services.	0 660			

Minnesota Department of Health

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0 660	Continued From page 17 On April 28, 2026, at 11:45 a.m., the surveyor observed ULP-E prepare meals for the residents in the kitchen. M-B, ULP-C, and ULP-E's employee record lacked TB history and symptom screening and baseline screening. On April 29, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they were new to the position and that the previous registered nurse may have completed the annual TB facility risk assessment and the employee TB history and symptom screening and baseline screening. CNS-A also stated they needed more time to go through the licensee's records to find the missing information. The licensee's undated Tuberculosis Screening/Prevention policy indicated [licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements. - risk assessment; - TB screening; and - staff education. The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) last updated March 9, 2026, indicated each provider licensed by MDH is required to complete a TB risk assessment annually. In addition, the FAQs indicated baseline TB screening includes: - assessing for current symptoms of active TB disease;	0 660			

Minnesota Department of Health

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0 660	Continued From page 18 - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680			

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0 680	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect 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, 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 the potential to affect a large portion or all of the residents). The findings include: The licensee's plan of correction (POC) dated March 10, 2024, indicated the licensee had developed a written documentation that included a disaster planning and emergency preparedness with all the required contents in a binder for staff to reference. On April 27, 2026, at 1:20 p.m., the surveyor requested to review the licensee's EPP. Administrator (A)-C stated they had a generic version in their binder and that they had not yet customized or printed their specific location's EPP. The licensee undated EPP lacked the following required content: - maintain and annual EPP updates; - EPP program patient population; - process for EPP collaboration; - development of EPP policies and procedures;	0 680			

Minnesota Department of Health

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0 680	Continued From page 20 - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - development of communication plan; - names and contact information; - emergency officials contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - LTC family notifications; - emergency prep training and testing; - emergency prep training program; - emergency prep testing requirements; and - integrated health systems. On April 27, 2026, at 2:30 p.m., A-C stated their EPP lacked required content indicated above. A-C also stated the licensee's management staff had talked about implementing their EPP. The licensee's undated Emergency Preparedness Plan - Appendix Z Compliance policy indicated it is the intent that [licensee] has in place an effective and compliant Emergency Preparedness Plan. The plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living	0 680			

Minnesota Department of Health

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0 680	Continued From page 21 facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=I	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: (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	0 780			

Minnesota Department of Health

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0 780	Continued From page 22 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers	0 790			

Minnesota Department of Health

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0 790	Continued From page 23 in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only 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 the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			

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0 800	Continued From page 24	0 800			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800			

Minnesota Department of Health

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0 800	Continued From page 25	0 800			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 810 SS=I	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 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.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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
0 810	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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0 900	Continued From page 27 directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract on or before the date of admission with the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
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0 900	Continued From page 28 affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on August 14, 2025, to receive assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated and signed April 28, 2026, during the survey, indicated R2 received medication administration, behavior management, bed making, dressing, deep room cleaning, grooming, housekeeping, laundry, meal reminder, and registered nurse monitoring and assessments. On April 29, 2026, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2. R2's record included an unsigned Resident Contract for Assisted Living dated December 5, 2024. When the surveyor pointed out the date, administrator (A)-D stated R2 previously lived in another assisted living location owned and managed by the licensee. A-D also stated R2 was transferred to the current location on August 14, 2025, and continued to receive assisted living services. A-D further stated they did not see the need to sign another contract as the licensee was the same except R2 changed locations. R3 R3 was admitted to the licensee on March 20, 2026, to receive assisted living services. R3's Service Plan - Addendum to Contract dated and signed April 28, 2026, during the survey, indicated R3 received the following services: dressing, laundry, managing behavior, bathing	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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0 900	Continued From page 29 reminder, bedmaking, and deep room cleaning. On April 29, 2026, at 8:25 a.m., the surveyor observed ULP-C administer medications to R3 in their room. R3's Resident Contract for Assisted Living was dated April 28, 2026, during the survey. The licensee failed to execute a written contract with the residents before providing assisted living services. On April 29, 2026, A-D stated they thought they had executed the contract with the residents; however, the residents had not signed it before receiving services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
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0 950	Continued From page 30 some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include verbatim language in the contract giving residents the right to identify a designated representative for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents 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 the potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted to the licensee on August 14, 2025, to receive assisted living services. R2's Resident Contract for Assisted Living was	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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0 950	Continued From page 31 dated December 5, 2024. R3 R3 was admitted to the licensee on March 20, 2026, to receive assisted living services. R3's Resident Contract for Assisted Living was dated April 28, 2026, during the survey. R2 and R3's Resident Contract for Assisted Living lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On April 29, 2026, at 2:26 p.m., administrator (A)-D stated they were not aware of the requirement. A-D also stated they had not been asked for the same in the previous surveys. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
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:	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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0 970	Continued From page 32 Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on August 14, 2025, to receive assisted living services. R3 was admitted to the licensee on March 20, 2026, to receive assisted living services. R2's unsigned Assisted Living Contract dated December 5, 2024, and R3's Assisted Living Contract dated April 28, 2026, during the survey, included the following sections that included language that waived the licensee's liability: - miscellaneous provisions section read, "The resident agrees that [the licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [the licensee] or its employees or agents. The resident hereby releases [the licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests,	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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0 970	Continued From page 33 or invitees, unless caused by the negligence of [the licensee] or its employees or agents." - Indemnification section read, "[the licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [the licensee] harmless from any claims or damages unless caused solely by negligence of [the licensee]." On April 29, 2026, at 3:20 p.m., administrator (A)-D stated they were not aware of the waiver in their contract. A-D also stated this had not been brought up in their previous surveys. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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01330	Continued From page 34 (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-E). 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 the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B started employment with the licensee on December 18, 2018, under the former comprehensive license and started to provide assisted living services on August 1, 2021. ULP-B's training record lacked documentation of training and competency evaluations in the following areas: training - recognizing physical, emotional, cognitive, and developmental needs of the resident. competency - standby assistance techniques and how to perform them; and	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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01330	Continued From page 35 - safe transfer techniques and ambulation. ULP-C ULP-C started employment with the licensee on March 2, 2023, to provide assisted living services. On April 29, 2026, at 8:25 a.m., the surveyor observed ULP-C administer medications to R3. ULP-C's training record lacked documentation of training and competency evaluations in the following areas: training - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. competency - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; and - safe transfer techniques and ambulation. ULP-E ULP-E started employment with the licensee on August 13, 2025, to provide assisted living services. ULP-E's training record lacked documentation of training and competency evaluations in the following areas: competency - safe transfer techniques and ambulation.	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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
01330	Continued From page 36 On April 29, 2026, at 1:00 p.m., administrator (A)-D stated registered nurse (RN) was responsible for staff training. Also, A-D stated their RN was on vacation. Clinical nurse supervisor (CNS)-A stated they were new to the licensee, and they had just started to audit employee records. The licensee's undated Competency Training Evaluations policy indicated when a registered nurse or licensed health professional staff of [licensee] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy also included all the missing content above as part of the required training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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01440	Continued From page 37 nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of three employees (unlicensed personnel (ULP)-C, ULP-E). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C started employment with the licensee on March 2, 2023, to provide assisted living services. On April 29, 2026, the surveyor observed ULP-C	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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01440	Continued From page 38 administer medications to R2 and R3. ULP-E ULP-E started employment with the licensee on August 13, 2025, to provide assisted living services. On April 28, 2026, at 11:47 a.m., the surveyor observed ULP-E administer as needed medications for pain to R3. ULP-C and ULP-E's record lacked documentation the RN completed supervision within 30 days for the delegated services ULP-C and ULP-E were providing. On April 29, 2026, at 1:00 p.m., administrator (A)-D stated the registered nurse (RN) was responsible for supervisions. Also, A-D stated their RN was on vacation. Clinical nurse supervisor (CNS)-A stated they were new to licensee, and they had just started to audit employee records. The licensee's undated Supervision of Unlicensed Staff policy indicated home health aides providing services to assisted living residents will be supervised to assure that the work is being performed competently and to identify problems and solutions to address issues relating to the employee's ability to provide the services. The policy also indicated direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. No further information was provided.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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01440	Continued From page 39	01440			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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
01500	Continued From page 40 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment that included the required annual training content for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-E). 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	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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01500	Continued From page 41 portion or all of the residents). The findings include: ULP-B ULP-B started employment with the licensee on December 18, 2018, under the former comprehensive license and started to provide assisted living services on August 1, 2021. ULP-B's My Transcript record dated March 3, 2023, and December 22, 2025, indicated ULP-B had completed annual training in the following topics for a total of 4 hours: - reporting maltreatment of vulnerable adults or minors - 1 hour; - review of provider's policies and procedures - 0.75 hours; - infection control techniques - 1 hour; and - principles of person-centered planning/service delivery - 1.25 hours. ULP-B's record lacked annual training in the following topics: - effective approaches to use to solve problems when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures. ULP-C ULP-C started employment with the licensee on March 2, 2023, to provide assisted living services. ULP-C's record lacked eight hours of annual training for the year 2025. ULP-E ULP-E started employment with the licensee on	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
(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
01500	Continued From page 42 August 13, 2025, to provide assisted living services. ULP-E's record lacked eight hours of annual training for the year 2025. On April 29, 2026, at 1:00 p.m., administrator (A)-D stated the licensee provided eight hours of annual training to all employees. A-D further stated they needed to have a better way to audit employee files for completed training. The licensee's undated Orientation and Annual Training Policy indicated all employees must participate in annual training to refresh and update their knowledge. The policy lacked the verbiage for the required annual training content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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01530	Continued From page 43 and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all staff received at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5). In addition, the licensee failed to ensure at least two hours of mental illness and de-escalation training specified under paragraph (b), clauses (6) to (8) within 160 working hours of the employment start date as required for three of three employees (unlicensed personnel (ULP)-B,	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
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01530	Continued From page 44 ULP-C, ULP-E). 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 the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B started employment with the licensee on December 18, 2018, under the former comprehensive license and started to provide assisted living services on August 1, 2021. ULP-B's record lacked two hours of initial training on mental illness and de-escalation. ULP-C ULP-C started employment with the licensee on March 2, 2023, to provide assisted living services. On April 29, 2026, at 8:25 a.m., the surveyor observed ULP-C administer medications to R3. ULP-C's record lacked two hours of initial training on mental illness and de-escalation. ULP-E ULP-E started employment with the licensee on August 13, 2025, to provide assisted living services. ULP-E's record lacked initial 8 hours of dementia care training. In addition, ULP-E's record lacked	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
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01530	Continued From page 45 two hours of initial training on mental illness and de-escalation all within 160 hours of employment start date. On April 29, 2026, at 1:30 p.m., administrator (A)-D stated all staff are assigned required dementia training at orientation. A-D also stated they were not aware of the requirement for mental illness and de-escalation. A-D further stated they did not have a system to audit their employee records in place. The licensee's undated Dementia Policy indicated all staff providing care in [licensee] will be knowledgeable in how to provide safe, effective services related to dementia. The policy lacked the verbiage to include mental illness, and de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=F	144G.70 Subd. 2 (a-b) 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	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
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01610	Continued From page 46 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. 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) completed an initial comprehensive nursing assessment on, or before, the date of admission for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on August 14, 2025, and began receiving assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R2 received medication administration, behavior management, meal reminder, grooming, housekeeping, laundry, linen change, bedmaking, dressing, deep room clean, and registered nurse monitoring and	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429		
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01610	Continued From page 47 assessments. On April 29, 2026, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2. R3 R3 was admitted to the licensee on March 20, 2026, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R3 received behavior management, laundry, bedmaking, dressing, deep room clean, bedmaking, and registered nurse monitoring and assessments. R2 and R3's record lacked documentation of a physical and cognitive assessment before they started receiving services. On April 29, 2026, at 1:30 p.m., administrator (A)-D stated R2 was admitted to another location owned by the licensee and moved to the current location to continue services. A-D also stated their previous registered nurse (RN) completed a paper assessment for R3, but they could not find it. Clinical nurse supervisor (CNS)-A stated they were aware of the initial assessment requirement. CNS-A also stated they had worked for the licensee in their capacity for only two weeks. The licensee's undated Assessment and Reassessment policy indicated the initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
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01610	Continued From page 48 unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
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; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429		
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01620	Continued From page 49 (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) completed a resident reassessment no more than 14 calendar days after initiation of services for two of two residents (R2, R3) and failed to complete ongoing resident reassessments at least every 90 days for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429			
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01620	Continued From page 50 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: R2 R2 was admitted to the licensee on August 14, 2025, and began receiving assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R2 received medication administration, behavior management, meal reminder, grooming, housekeeping, laundry, linen change, bedmaking, dressing, deep room clean, and registered nurse monitoring and assessments. On April 29, 2026, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2. R2's record included an unsigned undated assessment and another dated April 29, 2026, during the survey. R2's record lacked a 14-day assessment and re-assessments at least every 90 days and/or with change of condition. R3 R3 was admitted to the licensee on March 20, 2026, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey indicated R3 received behavior management, laundry, bedmaking, dressing,	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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
01620	Continued From page 51 deep room clean, bedmaking, and registered nurse monitoring and assessments. R3's record included an assessment completed on April 28, 2026, during the survey. R3's record lacked further assessments including a 14-day assessment. On April 29, 2026, at 1:30 p.m., administrator (A)-D stated R1 was admitted to another location owned by the licensee and moved to the current location to continue services. A-D also stated their previous registered nurse (RN) may have also completed paper assessment for R2 and R3, but they could not find them. Clinical nurse supervisor (CNS)-A stated they were aware of every 90-day assessment and with change of condition requirement. CNS-A also stated they had worked for the licensee in their capacity for only two weeks. The licensee's undated Assessment and Reassessment policy indicated the initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. The policy also indicated the RN will determine the frequency of re-assessments based on the client's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. No further information was provided.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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
01620	Continued From page 52	01620			
01640 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a service plan no later than 14 calendar days after the date that services are first provided. In addition, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
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01640	Continued From page 53 licensee to document agreement on the services to be provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on August 14, 2025, and began receiving assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R2 received medication administration, behavior management, meal reminder, grooming, housekeeping, laundry, linen change, bedmaking, dressing, deep room clean, and registered nurse monitoring and assessments. R3 R3 was admitted to the licensee on March 20, 2026, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R3 received behavior management, laundry, bedmaking, dressing, deep room clean, bedmaking, and registered nurse monitoring and assessments.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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
01640	Continued From page 54 R2 and R3's service plan was not signed and completed within 14 calendar days after the date that services were first provided. On April 29, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-A stated the service plan was supposed to be done by the former registered nurse (RN). CNS-A stated they had just been with the licensee for two weeks and they were still learning their documentation system. The licensee's undated Service Plan policy indicated the service plan, and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650			

Minnesota Department of Health

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01650	Continued From page 55 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on August 14, 2025, and began receiving assisted living services.	01650			

Minnesota Department of Health

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01650	Continued From page 56 R2's Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R2 received medication administration, behavior management, meal reminder, grooming, housekeeping, laundry, linen change, bedmaking, dressing, deep room clean, and registered nurse monitoring and assessments. R3 R3 was admitted to the licensee on March 20, 2026, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R3 received behavior management, laundry, bedmaking, dressing, deep room clean, bedmaking, and registered nurse monitoring and assessments. R2 and R3's services plan lacked required content to include the following: - the fees for services; and - a contingency plan that includes: - the names and contact information of people the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On April 29, 2026, at 1:20 p.m., administrator (A)-D stated they were not aware their service plan was missing required content. A-D also stated they updated their service plan recently and did not expect it to be missing content. The licensee's undated Service Plan policy	01650			

Minnesota Department of Health

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01650	Continued From page 57 indicated the service plan would include the following: - a description of the services to be provided and the description may be in the form of the residents care plan developed with the responsible party; - fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; - the identification of the staff or categories of staff who would provide the services; - the schedule and methods of monitoring reviews or assessments of the resident; - the schedule and method of monitoring staff providing services; and - a contingency plan that included the following: - action to be taken if the scheduled service could not be provided; - information and method for a resident or resident's representative to contact the facility; - names and contact information of people the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition; - the identification of and information as to who has the authority to sign for the resident in an emergency; - circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730			

Minnesota Department of Health

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01730	Continued From page 58 (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730			

Minnesota Department of Health

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01730	Continued From page 59 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include in the service plan medication management service for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R3 was admitted to the licensee on March 20, 2026, and began receiving assisted living services. R3's diagnoses included undifferentiated schizophrenia, paranoid schizophrenia, and uncomplicated bipolar disorder. R3 Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R3 received behavior management, laundry, bedmaking, dressing, deep room clean, bedmaking, and registered nurse monitoring and assessments. On April 29, 2026, at 8:25 a.m., the surveyor	01730			

Minnesota Department of Health

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01730	Continued From page 60 observed unlicensed personnel (ULP)-C administer medications to R3 in their room. R3's individual medication management plan dated April 28, 2026, signed during the survey, indicated R3 received medication management services. However, R3's service plan was missing medication management as a service R3 was receiving. R3's Medication Administration Record (MAR) dated March 20, 2206, through April 28, 2026, indicated R3 received medication management services upon their admission to the licensee. On April 29, 2026, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated they were aware R3 received medication administration. CNS-A also stated they were new to the licensee and had not gone through resident records to audit. The licensee's undated Service Plan policy indicated the service plan would include the following: - a description of the services to be provided and the description may be in the form of the resident's care plan developed with the party responsible; and - fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760			

Minnesota Department of Health

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01760	Continued From page 61 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 documentation for medication administration included the signature and title of the person who administered medications for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R3 was admitted to the licensee on March 20, 2026, and began receiving assisted living services. R3's diagnoses included	01760			

Minnesota Department of Health

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01760	Continued From page 62 undifferentiated schizophrenia, paranoid schizophrenia, and uncomplicated bipolar disorder. R3 Service Plan (Waiver) - Addendum to Contract dated April 28, 2026, signed during the survey, indicated R3 received behavior management, laundry, bedmaking, dressing, deep room clean, bedmaking, and registered nurse monitoring and assessments. On April 29, 2026, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3 in their room. R3's Medication Administration Record (MAR) dated March 20, 2206, through April 28, 2026, indicated R3 received the following medications: cholecalciferol vitamin D3 25 microgram (mcg) take by mouth one tablet daily, quetiapine 200 milligram (mg) give one tablet by mouth at bedtime, risperidone 3 mg give one tablet two times daily, and acetaminophen 500 mg tablet give one tablet by mouth every six hours as needed. R3's MAR indicated medications administered were documented by initials and lacked the corresponding signatures and title of the persons who completed the administration. On April 29, 2026, at 12:20 p.m., clinical nurse supervisor (CNS)-A stated they expected the missing information to be part of the MAR documentation. CNS-A also stated they were new to the licensee, and they were yet to audit the records. The licensee's undated Medication Management - Administration & Setup policy indicated	01760			

Minnesota Department of Health

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01760	Continued From page 63 assistance with medication and medication administration will be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	01810			

Minnesota Department of Health

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01810	Continued From page 64 The findings include: On April 28, 2026, at 1:57 p.m., the surveyor observed the licensee's medication cabinet and observed the following R3's expired medications: - three packets of acetaminophen 500 milligram (mg) take one tablet by mouth every six hours as needed for pain expired on January 11, 2025. On April 28, 2026, at 2:05 p.m., unlicensed personnel (ULP)-E stated the nurses were responsible for auditing and discarding medications. On April 30, 2026, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated they were responsible for medications. CNS-A also stated they were new and that they had not come yet to this facility to audit the medications. The licensee's undated Medication Disposal policy indicated the licensee would dispose of expired medications according to the accepted practices of the Minnesota Board of Pharmacy and the labels from the containers would be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to	03090			

Minnesota Department of Health

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03090	Continued From page 65 record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect residents, staff, and visitors to the 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 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 27, 2026, at 9:40 a.m., the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On April 30, 2026, at 11:59 a.m., administrator (A)-D stated they did not have the posting but would order stickers for all the doors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Page: 1

Establishment Info

Empire Systems Home Care
6012 YORK AVENUE NORTH
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34526

Risk:
License:
Expires on:
CFPM: EMMANUEL WHEAGAR
CFPM #: 39353; Exp: 8/29/2027

Inspection Info

Report Number: F8058261114
Inspection Type: Full - Single
Date: 4/27/2026 Time: 4:08:04 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-500C Microbial Control: date marking

3-501.17B Priority Level: Priority 2 CFP#: 23

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

COMMENT: OPENED HOT DOGS, LUNCH MEATS NOT MARKED WITH DATE

Comply By: 4/27/2026 Originally Issued On: 4/27/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A Priority Level: Priority 3 CFP#: 55

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

COMMENT: GREASE BUILT UP ABOVE VENT, CLEAN WALL AND CEILING OF GREASE, CLEAN VENT FILTERS

Comply By: 5/1/2026 Originally Issued On: 4/27/2026

Food & Beverage General Comment

HRD INSPECTOR BENARD NYANGENA

DISH WASHER 170
41 HOT DOG COOLER
41 CHICKEN COOLER

RESIDENTIAL HOME NON COMMERCIAL APPLIANCES AND FINISHES, WOOD CABINETS, LAMINATE FLOOR,
LAMINATE COUNTER, PAINTED SHEETROCK

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 F8058261114 from 4/27/2026

MOSES SANDO
PIC

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516

aaron.gertz@state.mn.us

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL34526016-0	Date: 4/29/2026
Facility Name: EMPIRE SYSTEMS HOME CARE	
Facility Address: 6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: Smoke alarms were missing in resident rooms 2, 3, and 5.

2. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: The smoke alarm was missing in the lower-level hallway.

3. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: Two separate smoke alarm systems were installed, a hardwired system and a wireless alarm, but each separate system was not interconnected. The hardwired smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers were installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguisher service tag was issued in 2023. No monthly inspections were recorded.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

Comments: The flooring throughout the house was delaminating, causing a potential trip hazard.

The shed in the rear yard was open and unsecured potentially harboring pests and rodents. Also a potential area for residents to be injured.

The main level bathroom shower had broken and missing tile around the tub and floor.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP was in a locked office. The staff onsite did not have a key and had to wait for the licensed assisted living director (LALD)-F to arrive to access the plan.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The evacuation plans did not match the identification being used on the resident rooms.

3. Each assisted living facility should develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-F stated a resident fire policy was not in place at the time of the survey.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-F stated staff training had been performed but was unable to provide documentation.

6. 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-F stated resident training had not been provided to the residents.