



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 11, 2025

Licensee

Empire Systems Home Care

6324 Scott Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL34525015

Dear Licensee:

On May 20, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 14, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor

State Engineering Services Section

Email: Tim.Hanna@state.mn.us

Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 27, 2025

Licensee

Empire Systems Home Care

6324 Scott Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL34525015

Dear Licensee:

On February 25, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 14, 2024. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the August 14, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 14, 2024, found not corrected at the time of the February 25, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on February 25, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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.

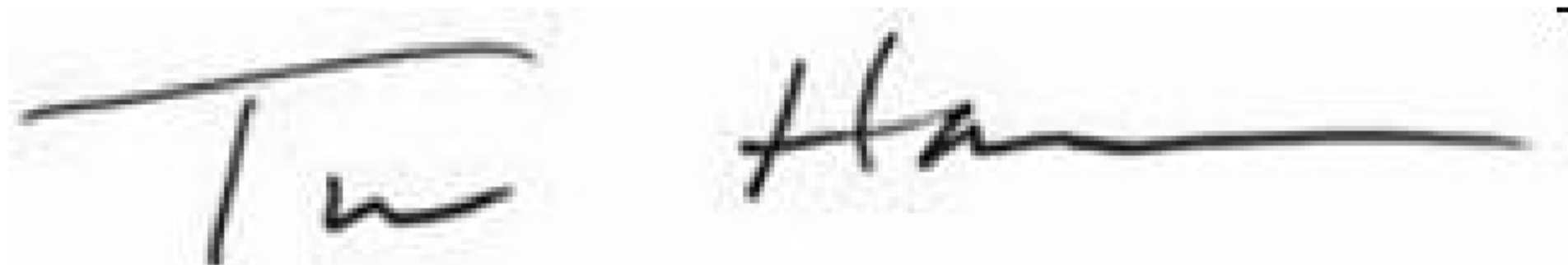
To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna", is written over a light gray rectangular background.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/25/2025
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6324 SCOTT 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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#34525015-2 On 2-24-2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on 8-14-2024. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}			
{0 570} SS=C	144G.42 Subdivision 1 Display of license	{0 570}	Not reviewed during this survey.		

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{0 570}	Continued From page 3 The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	{0 570}	Not reviewed during this survey.		
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			

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{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:	{0 660}	Not reviewed during this survey.		
{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	{0 680}			

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{0 680}	Continued From page 5 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{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:	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	{0 810}			

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{0 810}	Continued From page 6 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. This MN Requirement is not met as evidenced by:	{0 810}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	{0 820}	Not reviewed during this survey.		

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{0 820}	Continued From page 7 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 February 24, 2025, at 10:00 p.m., surveyor conducted a phone interview to follow-up on orders issued pursuant to a follow up survey completed on October 28, 2024. Surveyor spoke with the administrator (A)-F via telephone. A-F	{0 820}			

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{0 820}	Continued From page 8 stated no work was completed on the egress windows in bedrooms 1, 3, and 4. Surveyor asked for fire watch logs and any documents that showed progress has been made towards corrections. On February 25, 2025, A-F sent an e-mail to the surveyor containing fire logs for each day with signature in 30-minute intervals. The provided information was in accordance with facility proposed corrective measure to maintain the residents' safety until the window replacement was completed. A-F sent a permit for the windows, but property use listed Residential and not Commercial, a Plan Submittal Form and drawing for MDH to review has not yet been sent in. FINDINGS FROM INITIAL SURVEY ON August 14, 2024: Resident bedroom one measured 19 inches in height and 15.5 inches in width, with a total openable area of 294.5 square inches. Resident bedroom three measured 17 inches in height and 29 inches in width, with a total openable area of 493 square inches. Resident bedroom four measured 15 inches in height and 27 inches in width, with a total openable area of 405 square inches. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained that at least one egress window in each bedroom must be provided to meet the	{0 820}			

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{0 820}	Continued From page 9 minimum state standard for an egress window to be a complying bedroom for resident occupancy. No Further information was provided. OCCUPIED SLEEPING ROOMS: Bedroom 4: Window measured 27 inches clear width, 15 inches clear height, and 405 square inches total open area for each window. UNOCCUPIED SLEEPING ROOMS: Bedroom 1: Window measured 15.5 inches clear width, 19 inches clear height, and 294.5 square inches total open area. Bedroom 3: Window measured 29 inches clear width, 17 inches clear height, and 493 square inches total open area. The windows in bedroom 1 did not meet the minimum requirements for opening width. The windows in bedrooms 1, 3, 4 did not meet the minimum requirements for opening height. The windows in bedrooms 1, 3, 4 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-A that at least one window in each bedroom in a state-licensed	{0 820}			

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{0 820}	Continued From page 10 facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy and that an immediate correction order was issued for the above findings. HM-A stated they understood the requirements.	{0 820}			
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}			
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided;	{01370}	Not reviewed during this survey.		

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{01370}	Continued From page 11 (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) 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; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{01380}	Continued From page 12	{01380}	Not reviewed during this survey.		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}			
{01440} SS=F	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

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{01440}	Continued From page 13 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:	{01440}	Not reviewed during this survey.		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	{01470}			

Minnesota Department of Health

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{01470}	Continued From page 14 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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:	{01470}			

Minnesota Department of Health

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{01470}	Continued From page 15	{01470}	Not reviewed during this survey.		
{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. (b) In addition to the topics in paragraph (a),	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 16 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:	{01500}	Not reviewed during this survey.		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 17 specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	{01620}			

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{01620}	Continued From page 18 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must	{01760}			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EMPIRE SYSTEMS HOME CARE

**6324 SCOTT AVENUE NORTH
BROOKLYN CENTER, MN 55429**

Minnesota Department of Health
STATE FORM



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 17, 2024

Licensee

Empire Systems Home Care

6324 Scott Avenue North

Brooklyn Center, MN 55429

RE: Conditional License Number 418556
Health Facility Identification Number (HFID) 34525
Project Number(s) SL34525015

Dear Licensee:

On November 7, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 14, 2024. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a conditional assisted living facility license for 90-days, due to expire on **March 17, 2025**.

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

The total amount of **potential** fines that may be assessed related to these correction orders is \$500.00. **MDH is not imposing these fines against your license at this time.**

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 14, 2024, found not corrected at the time of the November 7, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on November 7, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

CONDITIONAL LICENSE ISSUED:

MDH will issue a conditional assisted living facility license for Empire Systems Home Care, for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Empire Systems Home Care is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **Health Facility Construction Permit:** Empire Systems Home Care, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Empire Systems Home Care, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.
- b. **General Contractor:** Empire Systems Home Care must provide the following to Tim Hanna (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:
 - i. Name
 - ii. License Number
 - iii. Contact Information
- c. **Egress Window Requirements:** Empire Systems Home Care will replace at least one window in occupied resident sleeping rooms #1, #3, and #4 meeting the minimum size requirements.
 - i. Must have a minimum openable width of no less than 20 inches
 - ii. Must have a minimum openable height of no less than 20 inches
 - iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
 - iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
 - v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Empire Systems Home Care is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Empire Systems Home Care is in substantial compliance on the follow up survey, MDH will remove the conditions from Empire Systems Home Care's assisted living facility license, and Empire Systems Home Care will correct any outstanding violations identified during the survey. If Empire Systems Home Care is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

Empire Systems Home Care

December 17, 2024

Page 4

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

JMD

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34525015-1 On October,28, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 14, 2024. At the time of the survey, there were two residents; receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued. *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 000}	Continued From page 1 INITIAL COMMENTS: SL34525015-1 On November 7, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 14, 2024. At the time of the survey, there were three residents; receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	{0 480}			
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.	{0 510}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 510}	Continued From page 2 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}	Not reviewed during this survey.		
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	{0 570}			
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 3 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{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:	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	{0 680}	Not reviewed during this survey.		

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{0 680}	Continued From page 4 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}			
{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.	{0 800}	Not reviewed during this survey.		

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{0 800}	Continued From page 5	{0 800}	Not reviewed during this survey.		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	{0 810}			

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{0 810}	Continued From page 6 drill. This MN Requirement is not met as evidenced by: No Further action needed.	{0 810}	Not reviewed during this survey.		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	{0 820}			

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{0 820}	Continued From page 7 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 October 28, 2024, at 12:00 p.m., surveyor conducted a phone interview to follow-up on orders issued pursuant to a survey completed on August 14, 2024. Surveyor spoke with the administrator (A)-F via telephone. The A-F stated work has not been completed. Surveyor asked for fire watch logs and any documents that showed progress has been made towards corrections. On October 31, 2024, A-F sent an e-mail to the surveyor containing fire logs for each day with signature in 15-minute intervals. The provided information was in accordance with facility proposed corrective measure to maintain the residents' safety until the window replacement was completed. No other information was sent. FINDINGS FROM INITIAL SURVEY ON August 14, 2024: Resident bedroom one measured 19 inches in height and 15.5 inches in width, with a total openable area of 294.5 square inches. Resident bedroom three measured 17 inches in height and 29 inches in width, with a total openable area of 493 square inches. Resident bedroom four measured 15 inches in height and 27 inches in width, with a total openable area of 405 square inches. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable	{0 820}			

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{0 820}	Continued From page 8 area (4.5 square feet) for the window. Survey staff explained that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. No Further information was provided.	{0 820}			
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for one of eleven employees (housing manager HM-A) on the facility provided employee roster. 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	{01290}			

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{01290}	Continued From page 9 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 7, 2024, at 10:45 a.m., the surveyor reviewed the facility's NETStudy 2.0 roster and compared it to the facility's staff roster and discovered one of the facility's eleven employees were not affiliated with the licensee's HFID 34525. HM-A was hired on May 9, 2018, to provide supportive services for the facility. A background study was not affiliated to the current HFID 34525. On November 7, 2024, at 11:00 a.m., HM-A stated she knows her background study was approved and was not sure why it was not showing up correctly on the roster. On November 8, 2024, at 9:40 a.m., administrator (A)-F stated he was sure this had been taken care of and will follow up with the department of human services to get it straightened out. The licensee's undated Background Studies policy indicated each facility employee/volunteer or contractor who will provide direct care to residents must have a background study completed. No further information was provided. TIME PERIOD FOR CORRECTION: 2 days	{01290}			

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{01370}	Continued From page 10	{01370}			
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) 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; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	{01370}			

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{01370}	Continued From page 11 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}			
{01440} SS=F	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	{01440}			

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{01440}	Continued From page 12 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 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: No Further action needed.	{01440}			
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	{01470}	Not reviewed during this survey.		

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{01470}	Continued From page 13 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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	{01470}			

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{01470}	Continued From page 14 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01470}	Not reviewed during this survey.		
{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	{01500}			

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{01500}	Continued From page 15 procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must	{01530}			

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{01530}	Continued From page 16 have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	{01620}			

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{01620}	Continued From page 17 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2024
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6324 SCOTT AVENUE NORTH BROOKLYN CENTER, MN 55429			
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{01760}	Continued From page 18	{01760}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			
			Not reviewed during this survey.		
			Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 13, 2024

Licensee

Empire Systems Home Care

6324 Scott Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL34525015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. 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>

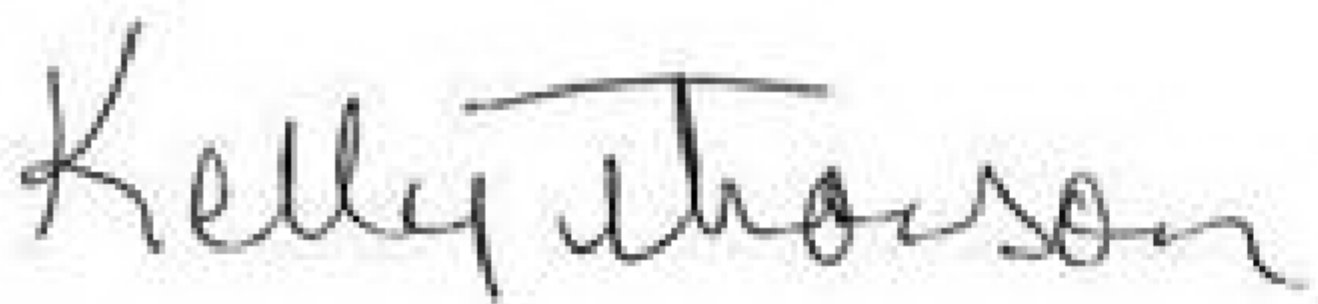
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6324 SCOTT AVENUE NORTH BROOKLYN CENTER, MN 55429			
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34525015 On August 12, 2024, through, August 14, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two resident(s); both receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and	0 510			

Minnesota Department of Health

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0 510	Continued From page 2 control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene and insulin administration. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 13, 2024, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-C perform blood glucose monitoring, medication administration, and insulin administration for R1. ULP-C failed to perform hand hygiene, ULP-C then logged into the electronic medication administration record (EMAR), checked R1's blood glucose reading via a libre system (electronic blood glucose reading system) and noted a reading of 44, encouraged R1 to drink some juice and milk, and eat breakfast. ULP-C made a note in the EMAR regarding the low blood	0 510			

Minnesota Department of Health

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0 510	Continued From page 3 glucose reading. ULP-C gathered medication punch packs and matched the medications against the EMAR and stated the nystatin powder was kept downstairs with R1 as she self administers the powder. ULP-C attached a needle to the insulin pen without first cleansing the hub of the insulin pen, dialed up 23 units of Lantus insulin and did not prime the insulin pen with 2 units. At this point ULP-C still failed to perform any hand hygiene or gloving. ULP-C gave R1 the oral medications with water. ULP-C then had R1 pull down the top of her pants and without cleansing the area first proceeded to inject the insulin into R1's upper left thigh. ULP-C then returned the insulin pen and the medication punch packs to the medication cabinet. No hand hygiene was performed after the medication and insulin administration. On August 13, 2024, at 8:20 a.m., ULP-C stated she was trained to wash her hands and to use gloves when completing medication and insulin administration and was trained to cleanse the injection site with an alcohol pad before injecting the insulin but was very nervous about being watched and just forget. On August 13, 2024, at 9:05 a.m., the surveyor observed ULP-C administer insulin to R1. ULP-C sanitized her hands and donned gloves. ULP-C attached a needle to the inulin pen without first cleansing the hub of the insulin pen, cleansed R1's upper right thigh with a "pre-moistened antibacterial wipe" and injected three units. ULP-C again did not prime the insulin pen. On August 14, 2024, at 11:00 a.m., clinical nurse supervisor stated staff should wash hands and use gloves when administering insulin. They should first cleanse the hub of the insulin pen	0 510			

Minnesota Department of Health

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0 510	Continued From page 4 before putting the needle on, they have been trained to cleanse the injection site with an alcohol pad before administering the insulin and they should wash hands before and after administering medication and insulin. ULP-C's training/competency document Injections-Subcutaneous dated May 17, 2023, indicated wash hands or use hand sanitizer, as appropriate, then don gloves, remove the pen cap and clean with alcohol wipe, then connect the needle to the pen, prime the pen, clean the pre-planned alternating injection site with alcohol wipe or soap and water. The Center of Disease Control (CDC) Core Infection Prevention and Control Practices regarding hand hygiene dated November 29, 2022, recommends healthcare personnel should use an alcohol-based rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated services, and immediately after glove removal. The licensee's undated Standard Precautions for All Health Care Workers policy indicated wash hands, gloves must be worn when cleaning reusable equipment, when having direct contact with blood, body fluids, mucous membranes, or non-intact skin, when handling items soiled with blood or when handling equipment contaminated with blood or body fluids. Gloves should be changed after each client contact. When gloves are removed, thorough hand washing is required.	0 510			

Minnesota Department of Health

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0 510	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the current assisted living license at the main entrance of the assisted living building. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On August 12, 2024, at 10:00 a.m., upon entering the facility, the surveyor did not observe a current assisted living license. On August 14, 2024, at 10:30 a.m., housing manager (HM)-A stated they had recently received a new license, so it was at the office	0 570			

Minnesota Department of Health

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0 570	Continued From page 6 instead of at the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required content for one of	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C began employment on January 12, 2021. On August 13, 2024, at 7:55 a.m., the surveyor observed ULP-C administer medications. ULP-C's employee record lacked the following: - documentation of a current annual performance review that identified areas of improvement needed and training needs. On August 13, 2024, at 2:30 p.m., housing manager (HM)-A stated they do annual performance reviews for staff and will have human resources look for the documentation. Documentation of performance reviews was not received. The licensee's undated Performance Evaluation policy indicated a competency-based performance evaluation will be conducted for all employees after one (1) year of employment and at least annually thereafter. The completed performance evaluation will be retained in the employee's personnel record, and a photocopy will be provided to the employee.	0 650			

Minnesota Department of Health

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0 650	Continued From page 8 The licensee's undated Personnel Records policy indicated the personnel record for an employee shall include, but not be limited to, the following: annual performance evaluation that identifies areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for	0 660			

Minnesota Department of Health

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0 660	Continued From page 9 Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, and a history and symptom screening for two of two employees unlicensed personnel (ULP)-C and clinical nurse supervisor (CNS)-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The facility TB risk assessment completed June 27, 2024, indicated the facility was at a low risk for TB transmission. ULP-C began employment on January 12, 2021, to provide direct care services. ULP-C's record lacked evidence a TB baseline screening to include either a TST or a blood test had been completed upon hire. The history and symptom screening document was dated September 11, 2020. CNS-B began employment on March 1, 2024, to provide direct care services. CNS-B's record indicated a TB baseline screening QuantiFERON gold blood test had been completed May 17, 2023. CNS-B's record lacked a history and symptom screening upon hire. On August 14, 2024, at 9:40 a.m., housing manager (HM)-A stated that many staff are born in other countries, so they do not get baseline	0 660			

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0 660	Continued From page 10 screenings because they are positive, so they just get a chest x-ray. HM-A further stated the TB screenings should be in the employee records. The licensee's undated Tuberculosis Screening policy indicated each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. For all employees, volunteers, or contract personnel providing direct resident care, there shall be evidence of baseline TB screening consisting of two components: a. assessing for current symptoms of active TB disease and b. testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test. If the employee has proof of a TB blood test or negative chest x-ray within 90 days of employment, it does not have to be repeated at the time of hire. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided.	0 660			

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0 660	Continued From page 11	0 660			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted	0 680			

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0 680	Continued From page 12 living license. The licensee also failed to post the plan in prominent area. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's, Emergency Preparedness Plan in Assisted Living dated May 1, 2024, lacked evidence of the following required content: - EPP reviewed and updated annually - quarterly review of missing resident - subsistence needs for staff and patients - policies and procedures for medical documents - policies and procedure for volunteers - arrangements with other facilities - development of communication plan - names and contact information - methods for sharing information - sharing information on occupancy and needs - emergency prep training program - long term care family notifications - roles under a wavier declared by secretary - emergency officials contact information; and - emergency preparedness testing requirements. POSTING On August 12, 2024, at 10:28 a.m., housing manager (HM)-A stated the EPP was not currently on site, it was probably taken to the office to be updated and not brought back.	0 680			

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0 680	Continued From page 13 On August 14, 2024, at 10:45 a.m., administrator (A)-F stated the EPP is at the office, and they can update anything that needs to be updated. It is usually kept on site but was at the business office to update. The licensee's undated Emergency Management policy indicated the facility will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subd. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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:	0 800			

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0 800	Continued From page 14 Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 13, 2024, from approximately 10:15 a.m. to 11:45 a.m., survey staff toured the facility with house manager (HM)-A. The following was observed. GENERAL MAINTENANCE: Kitchen vinyl floor was peeling up throughout. Wall in the living room by the front door closet had a hole in it. Living room wall had several areas that were patched with putty and in need of some paint. No outlet covers on the plug in under the dining room window. Paint was coming off the door trim in the	0 800			

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0 800	Continued From page 15 bedrooms and bathroom on the main floor. Bedroom #2 window trim was scratched and missing paint. Wall was missing paint and ceiling fan blades were heavily soiled with dust. Vent in hallway main-floor was heavily soiled with dust. Main-floor bathroom door had holes and scratches in it. Bedroom #1 had a heavily soiled vent. Basement wall in laundry room had water stains and water coming in from an outside source. Deck finish was coming off and wood was deteriorating. HM-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810			

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0 810	Continued From page 16 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 810			

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0 810	Continued From page 17 the residents). The findings include: On August 13, 2024, at approximately 11:30 a.m., house manager (HM)-A failed to provide documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: This facility failed to provide any documentation for the fire safety and evacuation plan while onsite so I requested from the HM-A to email this documentation and she failed to do so. TRAINING and Drills: The licensee failed to provide evacuation training and drills to staff and residents as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the	0 820			

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0 820	Continued From page 18 commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 13, 2024, from approximately 10:15 a.m. to 11:25 a.m., survey staff toured the facility with house manager (HM)-A. During the tour, survey staff asked HM-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 4: Window measured 27 inches clear width, 15 inches clear height, and 405 square inches total open area for each window. UNOCCUPIED SLEEPING ROOMS: Bedroom 1: Window measured 15.5 inches clear width, 19 inches clear height, and 294.5 square inches total open area.	0 820			

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0 820	Continued From page 19 Bedroom 3: Window measured 29 inches clear width, 17 inches clear height, and 493 square inches total open area. The windows in bedroom 1 did not meet the minimum requirements for opening width. The windows in bedrooms 1, 3, 4 did not meet the minimum requirements for opening height. The windows in bedrooms 1, 3, 4 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy and that an immediate correction order was issued for the above findings. HM-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Immediate.	0 820			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290			

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01290	Continued From page 20 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for four of thirteen employees (unlicensed personnel/ULP-C, ULP-D, ULP-E, and housing manager HM-A) on the facility provided employee roster. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On August 13, 2024, at 9:30 a.m., the surveyor reviewed the facility's NETStudy 2.0 roster and compared it to the facility's staff roster and discovered four of the facility's thirteen employees were not affiliated with the licensee's HFID	01290			

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01290	Continued From page 21 34525. HM-A was hired on May 8, 2018, to provide supportive services for the facility. A background study was not affiliated to the current HFID 34525. ULP-C was hired on January 12, 2021, to provide direct care and services to the licensee's residents. A background study was not affiliated to the current HFID 34525. ULP-D was hired on October 24, 2022, to provide direct care and services to the licensee's residents. A background study had not been submitted for ULP-D. ULP-E was hired on August 17, 2023, to provide direct care and services to the licensee's residents. A background study was not affiliated to the current HFID 34525. On August 13, 2024, at 11:15 a.m., HM-A stated she does not know why the employees are not showing up on the Net study rosters. HM-A stated she knows the background studies were completed. The licensee's undated Background Studies policy indicated each facility employee/volunteer or contractor who will provide direct care to residents must have a background study completed. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			

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01370	Continued From page 22	01370			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) 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; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370			

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01370	Continued From page 23 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed upon hire for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on January 12, 2021. On August 13, 2024, at 7:55 a.m., the surveyor observed ULP-C administer medications. ULP-C's employee record lacked documentation of the following competency evaluations to be completed by ULP: -care and use of hearing aids -standby assist techniques and how to perform them On August 14, 2024, at 11:12 a.m., housing manager (HM)-A stated the documentation of the missing competencies may be in another folder at the office. The surveyor did not receive the missing competency records. The licensee's undated Competency Evaluations	01370			

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NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6324 SCOTT AVENUE NORTH BROOKLYN CENTER, MN 55429			
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01370	Continued From page 24 policy indicated training and competency evaluations for all unlicensed personnel must include the following: -care and use of hearing aids -standby assist techniques and how to perform them The licensee's undated Qualifications, Training, and Competency policy indicated training and competency elvauations for all unlicensed personnel will include the following: -care and use of hearing aids -satandby assistance techniques and how to perform them No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as	01380			

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01380	Continued From page 25 required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed upon hire for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on January 12, 2021. On August 13, 2024, at 7:55 a.m., the surveyor observed ULP-C administer medications. ULP-C's employee record lacked documentation of the following competency evaluations to be completed by ULP: -reading and recording temperature, pulse, and respirations of the resident -range of motion and positioning On August 14, 2024, at 11:12 a.m., housing manager (HM)-A stated the documentation of the missing competencies may be in another folder at the office. The surveyor did not receive the missing competency records. The licensee's undated Competency Evaluations policy indicated training and competency	01380			

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01380	Continued From page 26 evaluations for all unlicensed personnel must include the following: -reading and recording temperature, pulse, and respirations of the resident -range of motion exercises and positioning The licensee's undated Qualifications, Training, and Competency policy indicated training and competency evaluations for all unlicensed personnel will include the following: -reading and recording temperature, pulse, and respirations of the resident -range of motion and positioning No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	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 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	01440			

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01440	Continued From page 27 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 one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on January 12, 2021. On August 13, 2024, at 7:55 a.m., the surveyor observed ULP-C administer medications. ULP-C's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services.	01440			

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01440	Continued From page 28 On August 14, 2024, at 11:14 a.m., housing manager (HM)-A stated they do not complete 30-day supervisions, they do 90-day supervisions. HM-A further stated she was not aware of this requirement. The licensee's undated Supervision of Unlicensed Personnel policy indicated 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 delegated tasks for residents, and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning	01470			

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01470	Continued From page 29 and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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:	01470			

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01470	Continued From page 30 Based on interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: CNS-B began employment on March 1, 2024. CNS-B's employee record lacked the following required orientation content: -overview of assisted living statutes -review of provider's policies and procedures -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -handling of resident complaints, reporting of complaints, where to report -consumer advocacy services -review of the types of assisted living services the employee will provide and provider's scope of license On August 14, 2024, at 12:12 p.m., housing manager (HM)-A stated she had no idea the nurse was missing so much orientation training and did not know why. The licensees undated Facility Employee	01470			

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01470	Continued From page 31 Orientation policy indicated all employees of the Assisted Living Facility, including those who provide direct care, supervision of direct care, or management of services for the facility, shall complete an orientation on topics required by Minnesota statutes and rules for assisted living. The state required orientation to home care must include the following: -an overview of Minnesota's home care law (MN statutes 144A.43 to 144A.4798) -an introduction and review of all facility's policies and procedures related to the provision of home care services -handling of emergencies and use of emergency services -reporting the maltreatment of vulnerable minors or adults -the home care bill of rights (Minnesota statutes 144A.44) -overview of the home care statute and licensure rules -handling of emergencies and use of emergency services -reporting the maltreatment of vulnerable adults or minors -assisted living bill of rights -handling of residents' complaints and reporting of complaints to the Office of health Facility Complaints -consumer advocacy services of the Ombudsman for Long-Term care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates and other relevant advocacy services -a review of the types of services the employee will be providing and the scope of the facility's services under the specific license No further information was provided.	01470			

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01470	Continued From page 32	01470			
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	01500			

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01500	Continued From page 33 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01500			

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01500	Continued From page 34 The findings include: ULP-C had a hire date of January 12, 2021. On August 13, 2024, at 7:55 a.m., the surveyor observed ULP-C administer medications. ULP-C's record lacked evidence of annual training to include: -a review of the providers policies and procedures On August 14, 2024, at 11:16 a.m., housing manager (HM)-A stated the review of their policies should be part of the annual training and is sure ULP-C completed it, but they just can't find the documentation. The licensee's undated Annual Training Requirements policy indicated annual training must include a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics	01530			

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01530	Continued From page 35 related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the supervisor of direct care staff received eight hours of initial dementia care training within the first 120 hours worked for one of one employee (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01530			

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01530	Continued From page 36 CNS-B began employment on March 1, 2024. CNS-B's orientation and training record lacked documentation of the required number of hours of dementia care training. The training record dated January 15-16, 2024, included: -dementia- activities- a balanced approach 0.75 -dementia- communication- overview 1.00 -dementia- person-centered care 0.75 -dementia- problem solving- overview 0.75 On August 14, 2024, at 12:12 p.m. housing manager (HM)-A stated the nurse only had 3.25 hours of dementia training and had worked more than 120 hours since she started. HM-A further stated she did not know the nurse was missing all this training. The licensee's undated Dementia Care Training policy indicated supervisors of direct-care staff must have at least eight hours of initial training within 120 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620			

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01620	Continued From page 37 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) assessed a resident for self-administration of medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, traumatic brain	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6324 SCOTT 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 38 injury, and hypertension. R1's Addendum to Contract (service plan), dated January 9, 2024, indicated R1 received medication administration assistance six times a day. R1's 90-Day assessment dated July 2, 2024, indicated R1 required assistance with medication administration. On August 13, 2024, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications for R1. When ULP-C gathered supplied and medications she stated R1's nystatin powder was kept downstairs in her room as she self-administers the powder. R1's medication administration record (MAR) dated August 2024, indicated nystatin powder 100000 daily, apply to skin twice daily- apply to skin under/between breasts. R1's provider order signed August 13, 2024, indicated nystatin (mycostatin) 100,000 unit/gram topical powder, apply to skin twice a day, apply to skin under/between breasts. On August 14, 2024, at 12:35 p.m., housing manager (HM)-A stated R1 has always self administered her nystatin powder, there is no way she would let us do that. HM-A further stated a self-administer should be on the provider order and the nurse should follow up on it. The licensee's undated Medication Management Services policy indicated based on the nursing assessment, the RN will develop an individualized medication management plan for each resident receiving any type of medication management	01620			

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01620	Continued From page 39 services, consistent with current practice standards and guidelines and will develop specific procedures for medication management services that staff will provide. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) prepared in writing specific instructions for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
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01750	Continued From page 40 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: During the entrance conference on August 12, 2024, at 11:15 a.m., housing manager (HM)-A stated the licensee provided medication management services to residents at the facility. R1 admitted to the licensee on December 4, 2020. R1's diagnoses included diabetes mellitus. R1's service plan dated January 9, 2024, indicated R1 received services including medication administration. R1's prescriber orders dated April 2, 2024, included: -insulin lispro Kwikpen 100u/mL For: Humalog Kwikpen (insulin pen/a multiple dose pen shaped injector device used for insulin administration) inject 3 units subcutaneously three times daily after meals. *discard pen 28 days after first use, do not refrigerate after first use* -Lantus Solostar 100unit/mL pen inject 23 units subcutaneously twice daily. *discard pen 28 days after first use, do not refrigerate after first use* R1's electronic medication administration record (EMAR) dated August 2024, included: -Humalog Kwikpen 100unit/mL inject 3 units subcutaneously three times daily after meals *discard pen 28 days after first use, do not refrigerate after first use* -insulin glar inj 100u/mL daily inject 23 units subcutaneously twice daily. *discard pen 28 days after first use, do not refrigerate after first use*	01750			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
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01750	Continued From page 41 On August 13, 2024, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-C perform medication administration, blood glucose monitoring, and insulin administration for R1. ULP-C checked the electronic medication administration record (EMAR) to check the dose of Lantus insulin to give. ULP-C failed to perform hand hygiene or apply gloves, applied a needle to the insulin pen without first cleaning the tip of the pen, dialed the insulin pen to 23 units and injected the insulin into R1's upper left thigh without cleansing the area first or priming the insulin pen. On August 13, 2024, at 9:05 a.m. the surveyor observed ULP-C perform insulin administration for R1. ULP-C sanitized hands, donned gloves, checked the EMAR, applied a needle to the Humalog insulin pen without first cleansing the tip, cleansed R1's upper right thigh with a pre-moistened antibacterial wipe and injected 3 units without first priming the pen. On August 13, 2024, at 2:00 p.m. ULP-C stated she does not prime the insulin pen first, she just dials up the correct dose of insulin. ULP-C's training record dated May 7, 2023, indicated she passed a competency demonstration regarding insulin subcutaneous injections to include prime the pen per manufacturer instructions (see MAR); to remove any air bubbles that may be present. On August 14, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated there are no specific instruction on the MAR regarding priming the insulin pens before administering the insulin. The expectation is for staff to prime the pen with two units.	01750			

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01750	Continued From page 42 The licensee's undated Documentation of Medication Administration policy indicated staff will refer to the medication profile listing the medication name, strength, description, amount to be given, and time of day to be given, as well as the purpose of the medication and any special instructions, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescriber orders were transcribed accurately for one of one resident (R1). This practice resulted in a level two violation (a	01760			

Minnesota Department of Health

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01760	Continued From page 43 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 13, 2024, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's medications. R1 had diagnoses including diabetes, traumatic brain injury, and hypertension. R1's provider orders signed April 2, 2024, included the following scheduled medications: -Certavite tabs- take one tablet my mouth once daily- supplement -ciclopirox solution 8% apply to nail once daily for onychomycosis -farxiga tab 10 mg take 1 tablet by mouth once daily for blood pressure -loperamide 2 mg caps take 2 capsules by mouth every morning for loose stools -nicotine TD 14mg/24hours apply 1 patch to clean dry hairless skin once daily. Remove old patch before applying new patch- for smoking cessation. -nicotine TD 21mg/24hours apply 1 patch to clean dry hairless skin once daily. Remove old patch before applying new patch. -omeprazole 20 mg take 1 capsule by mouth once daily for heartburn -vitamin D3 25mcg (1000IU) cap take 2 capsules (2000IU) by mouth once daily for supplement -gabapentin tab 600 mg take 2 tablets (1200mg)	01760			

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01760	Continued From page 44 by mouth twice daily for polyneuropathy -Lantus Solostar 100unit/ml pen inject 23 units subcutaneously twice daily for diabetes -atorvastatin tab 20 mg take 1 tablet by mouth once daily for cholesterol -risperidone tab 2 mg take 1 tablet by mouth every evening for bipolar -insulin lispro Kwikpen 100u/ml inject 3 units subcutaneously three times daily after meals for diabetes -melatonin tab 3 mg take 1 tablet by mouth at bedtime for sleep -senna-time tab 8.6 mg take 1 tablet by mouth at night but may increase to take 1 tablet twice daily if no bowel movement for constipation -mounjaro injection 10mg/0.5 inject 0.5ml (10mg) subcutaneously once a week for diabetes R1's medication administration record (MAR) for August 2024, showed the following: -aspirin low tab 81 mg ec take 1 tablet by mouth once daily -daily-vite tab take 1 tablet by mouth once daily *not given 9/12 days -Farxiga tab 10 mg take 1 tablet by mouth once daily -gabapentin tab 600 mg take 2 tablets (1200mg) by mouth twice daily *not given 3/23 times -insulin glargine 100u/ml inject 23 units subcutaneously twice daily -loperamide 2 mg caps give 2 capsules (4mg) by mouth every morning for diarrhea -nystatin powder 100000 apply to skin twice daily apply to skin under/between breasts -omeprazole 20 mg caps take 1 capsule by mouth once daily -vitamin B-12 tablet 1000mcg take 1 tablet by mouth once a week	01760			

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01760	Continued From page 45 -vitamin D3 25mcg (1000iu) capsule take 2 capsules (2000iu) by mouth once daily *MAR shows to give every Tuesday- just once a week -Humalog Kwikpen 100unit/ml inject 3 units subcutaneously three times daily after meals -folic acid tab 400mcg take 1 tablet by mouth once a week *not given -mounjaro 7.5/0.5 inject 0.5ml (7.5mg) subcutaneously once a week *not given -amlodipine besylate 10 mg tab take 1 tablet by mouth at bedtime *not given 2/11 days -atorvastatin tab 20 mg take 1 tablet by mouth once daily *not given 6/11 days -risperidone tablet 2 mg take 1 tablet by mouth every evening *not given 11/11 times -senna time tab 8.6 mg take 1 tablet by mouth at night but may increase to take 1 tablet twice daily if no bowel movement *not given 1/11 times -melatonin tab 3mg take 1 tablet by mouth at bedtime *not given 9/11 times On August 14, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of the differences between the medication list from the doctor and the MAR. CNS-B further stated she was aware of the missing and not given meds and needed to follow up with that. The licensee's undated Medication Management Services policy indicated the RN will develop and update as needed specific procedures for the following medication management activities: requesting and receiving prescriptions for current and changing medications, implementing new prescriptions, and updating the resident's medication record and medication management plan, when necessary. No further information was provided.	01760			

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01760	Continued From page 46	01760			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the opened or expiration date. 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 the residents). The findings include: On August 12, 2024, at 1:40 p.m. the surveyor observed the medication cabinet and found the following: - One Lantus insulin pen without an opened or expiration date - One Humalog insulin pen without an opened or expiration date	01890			

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01890	Continued From page 47 Manufacturer's instructions for both Lantus and Humalog indicate injection pens should be used within 28 days after opening. On August 12, 2024, at 1:40 p.m., unlicensed personnel (ULP)-C stated they usually do date the insulin pens when they open a new one, but the marker they were using was dry and kept wiping off. On August 14, 2024, at 11:17 a.m. clinical nurse supervisor (CNS)-B stated staff should be dating insulin pens when they are opened, it is part of the medication training. The licensee's Competencies 2.23 Injections-Subcutaneous document indicated staff should check the expiration date on the medication container and the handwritten date indicating the open date of the medication, if applicable. Ensure medication is not expired. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Type: Full
Date: 08/13/24
Time: 10:00:00
Report: 1005241186

Food and Beverage Establishment Inspection Report

Page 1

Location:

Empire Care Systems Llc
6324 Scott Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0037660
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636570298
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-702.11 **** Priority 1 ****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning. DISHES ARE BEING WASHED AND RINSED IN A SINGLE SINK BASIN, AND ARE NOT BEING SANITIZED. DISCUSSED USING A SEPARATE BIN FOR SANITIZING UNTIL A DISHWASHER IS PROVIDED.

Comply By: 08/13/24

3-500C Microbial Control: date marking

3-501.17B **** Priority 2 ****

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.

OPENED MILK AND LETTUCE IN THE FRIDGE WERE NOT DATE MARKED. TCS FOODS MUST BE MARKED WITH THE DATE THEY ARE OPENED, AND USED OR DISCARDED WITHIN 7 DAYS. FACT SHEET LEFT ON SITE.

Comply By: 08/13/24

4-300 Equipment Numbers and Capacities

4-301.12A **** Priority 2 ****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

FACILITY HAS NO 3-COMPARTMENT SINK OR DISHWASHER. PROVIDE A 3-COMP SINK OR DISHWASHER TO PROPERLY WASH, RINSE, AND SANITIZE DISHES.

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Food and Beverage Establishment Inspection Report

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Comply By: 11/13/24

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

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

THERE IS NO FOOD THERMOMETER ON SITE.

Comply By: 08/20/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

THE AMBIENT THERMOMETER IN THE REFRIGERATOR WAS BROKEN AND NOT GIVING AN ACCURATE READING. PROVIDE A NEW THERMOMETER.

Comply By: 08/20/24

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK

Temperature: 38 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: Cold Hold/LETTUE

Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR

Violation Issued: No

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

INSPECTION COMPLETED WITH HOUSE MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR WENDY ROBARGE.

FACILITY DOES NOT HAVE A 3-COMPARTMENT SINK OR A DISHWASHER, AND IS NOT CURRENTLY SANITIZING DISHES. DISCUSSED USING A SEPARATE DISH BIN WITH BLEACH WATER MIXED TO 50-100 PPM CHLORINE TO SANITIZE DISHES, UNTIL A DISHWASHER OR 3-COMPARTMENT SINK IS PROVIDED. INSPECTOR LEFT CHLORINE TEST STRIPS ON SITE FOR OPERATOR.

DISCUSSED THAT FACILITY NEEDS TO PROVIDE EITHER A 3-COMPARTMENT SINK AND SANITIZE WITH CHEMICAL, OR A DISHWASHER THAT SANITIZES WITH HEAT (REQUIRED UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE).

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

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

Type: Full
Date: 08/13/24
Time: 10:00:00
Report: 1005241186
Empire Care Systems Llc

Food and Beverage Establishment Inspection Report

Page 3

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1005241186 of 08/13/24.

Certified Food Protection Manager: EMMANUEL R. WHEAGOR

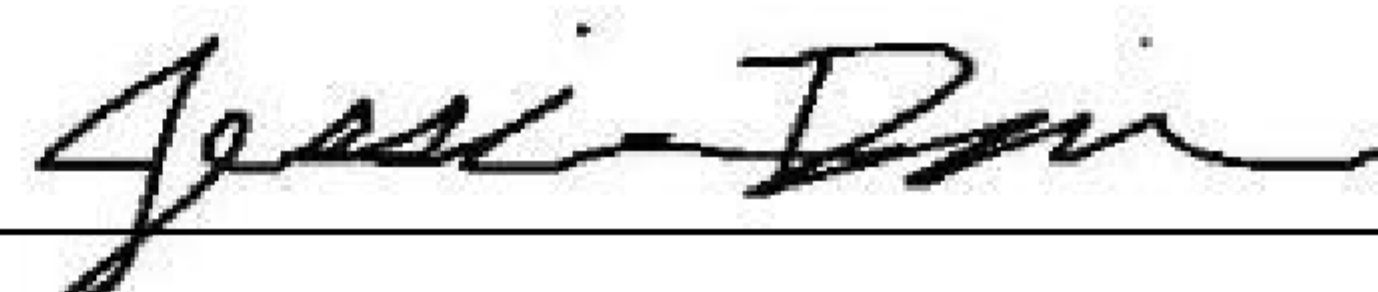
Certification Number: FM108016 Expires: 08/28/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

GBESSAY GRACE KEMOKAI
HOSUE MANAGER

Signed: _____



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