



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 25, 2025

Licensee

Empire Systems Home Care

3301 Lawrence Road

Brooklyn Center, MN 55429

RE: Project Number(s) SL35562015

Dear Licensee:

On July 10, 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 21, 2024 and the follow-up surveys completed on November 26, 2025 and February 12, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

Tim Hanna, Supervisor

State Engineering Services Section

Health Regulation Division

Email: Tim.Hanna@state.mn.us

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 23, 2025

Licensee

Empire Systems Home Care

3301 Lawrence Road

Brooklyn Center, MN 55429

RE: Project Number(s) SL35562015

Dear Licensee:

On February 12, 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 21, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 21, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 21, 2024, found not corrected at the time of the February 12, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on February 12, 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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,



Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35562	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/12/2025
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 LAWRENCE ROAD BROOKLYN CENTER, MN 55429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL3556215-2 On February 11, 2025, and February 13, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider on orders issued pursuant to a survey completed on November 26, 2024. At the time of the survey, there were five residents: five 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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	{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 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	{0 480}			

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{0 480}	Continued From page 2 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}			
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following 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: Not reviewed during this survey.	{0 650}			

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{0 660}	Continued From page 3	{0 660}			
{0 660} SS=D	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: Not reviewed during this survey.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 4 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: Not reviewed during this survey.	{0 680}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	{0 780}			

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPIRE SYSTEMS HOME CARE	3301 LAWRENCE ROAD BROOKLYN CENTER, MN 55429

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{0 820}	Continued From page 8 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 11, 2025, at 4:00 p.m., the surveyor requested documentation to support corrective actions taken on orders issued pursuant to a survey completed on November 27, 2024, for non-compliant egress windows in two resident sleeping rooms. The surveyor requested copies of the following documents from care giver (CG)-L and owner (O)-N: 1. Copies of completed fire watch records for resident occupied bedrooms with non-compliant egress windows. 2. A copy of the building permit from the city for the egress window installations. 3. Verification that a plan review application had been submitted to the Minnesota Department of Health Engineering Services for the egress window installations. Record review indicated fire watches had not been completed every day. No fire watch records were provided between February 9, 2025, and February 11, 2025. Additionally, record review indicated fire watches had not been completed every 30 minutes on the following dates: January 10, 2025 - times were not recorded between 3:30 p.m. and 9:00 p.m. January 11, 2025 - times were not recorded between 3:30 p.m. and 10:30 p.m.	{0 820}			

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{0 820}	Continued From page 9 January 15, 2025 - times were not recorded between 3:30 p.m. and 10:30 p.m. January 16, 2025 - times were not recorded between 3:30 p.m. and 10:30 p.m. In an interview on February 11, 2025, at approximately 4:05 p.m., CG-L stated fire watches were not recorded because the printer was not working and verified the fire watch logs were incomplete. In an interview on February 11, 2025, at approximately 4:05 p.m., O-N stated the widows had not yet been replaced and they were working with a contractor on the egress window replacements. O-N stated the weather had been too cold and the tentative date scheduled for the window installations was March 24, 2025. O-N stated they had spoken with the city and were planning to get the permit on Friday and verified a plan review application had not been submitted to Minnesota Department of Health Engineering Services yet. On February 13, 2025, at 2:45 p.m., the surveyor toured the facility with certified nursing assistant (CNA)-M. During the tour, the surveyor observed the egress windows had not been replaced in occupied resident bedrooms 2 and 4. During the tour interview, CNA-M verified the above listed observations.	{0 820}			
{01370} SS=D	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}			

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{01370}	Continued From page 10 (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: Not reviewed during this survey.	{01370}			

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{01380}	Continued From page 11	{01380}			
{01380} SS=D	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: Not reviewed during this survey.	{01380}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	{01500}			

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{01500}	Continued From page 12 (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), 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	{01500}			

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{01500}	Continued From page 13 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: Not reviewed during this survey.	{01500}			
{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: Not reviewed during this survey.	{01760}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	{01880}			

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{01880}	Continued From page 14 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35562	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/12/2025
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 LAWRENCE ROAD 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
{01940}	Continued From page 15 by: Not reviewed during this survey.	{01940}			
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 3, 2025

Licensee

Empire Systems Home Care

3301 Lawrence Road

Brooklyn Center, MN 55429

RE: Project Number(s) SL35562015

Dear Licensee:

On November 26, 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 21, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 21, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 21, 2024, found not corrected at the time of the November 26, 2024, 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 November 26, 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 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 Benjamin J. Zwart at 651-201-3715.

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 that reads "Benjamin J. Zwart". The signature is written in a cursive style with a horizontal line extending from the end of the name.

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35562	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
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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: SL3556215-1 On November 26, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider on orders issued pursuant to a survey completed on August 21, 2024. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently	{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 enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and 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.	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2	{0 480}			
	This MN Requirement is not met as evidenced by: Not reviewed during this survey.				
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following 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: Not reviewed during this survey.	{0 650}			
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 3 (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: Not reviewed during this survey.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 4 (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: Not reviewed during this survey.	{0 680}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 5	{0 780}			
{0 790} SS=F	This MN Requirement is not met as evidenced by: Not reviewed during this survey. 144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 790}			
{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}			

Minnesota Department of Health

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{0 800}	Continued From page 6	{0 800}			
{0 810} SS=F	This MN Requirement is not met as evidenced by: Not reviewed during this survey. 144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}			

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{0 810}	Continued From page 7	{0 810}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect two residents and all staff. 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).	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 8 The findings include: On November 26, 2024, the surveyor emailed the licensee requesting documentation to support corrective actions taken on orders issued pursuant to a survey completed on August 21, 2024, for non-compliant egress windows in two resident sleeping rooms. The surveyor requested copies of the following: 1. Copies of all completed fire watch records for resident occupied bedrooms with non-compliant egress windows. 2. A copy of the building permit from the city for the egress window installations. 3. Verification that a plan review application has been submitted to the Minnesota Department of Health Engineering Services for the egress window installations. On November 27, 2024, the licensee responded: The widows have not yet been replaced. We were finally able to find someone who has the availability and whom we can afford, to do the work. He started work on 6324 Scott Ave N (HFID 34525) last week to replace 3 windows over there, as that survey was done earlier. He is expected to be done by the end of next week and then he will move on to 3301 Lawrence Road. I do not have the drawings, as we just secured a contractor to do the work and the architect has to do the drawing in collaboration with the contractor. We also found an architect but he will not be able to do the drawing until after the Thanksgiving holiday; possibly on Tuesday next week. The licensee emailed fire watch records to the surveyor on November 27, 2024.	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 9 On August 22, 2024, the surveyor emailed the licensee information on how to obtain a building permit from the Minnesota Department of Labor and Industry (DLI) or municipalities having State Delegation Agreements with DLI for the new egress window installations. On August 22, 2024, and November 18, 2024, the surveyor emailed the licensee information on the Minnesota Department of Health engineering services plan review application process as required under MN Statute 144G for the new egress window installations. No further information was provided from the licensee.	{0 820}			
{01370} SS=D	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	{01370}			

Minnesota Department of Health

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{01370}	Continued From page 10 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: Not reviewed during this survey.	{01370}			
{01380} SS=D	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,	{01380}			

Minnesota Department of Health

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{01380}	Continued From page 11 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: Not reviewed during this survey.	{01380}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	{01500}			

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NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 LAWRENCE ROAD BROOKLYN CENTER, MN 55429			
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{01500}	Continued From page 12 (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01500}			
{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}			

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{01760}	Continued From page 13 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: Not reviewed during this survey.	{01760}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	{01940}			

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{01940}	Continued From page 14 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01940}			
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02310}			

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 26, 2024

Licensee

Empire Systems Home Care

3301 Lawrence Road

Brooklyn Center, MN 55429

RE: Project Number(s) SL35562015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 21, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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: 35562	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2024
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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: SL35562015 On August 19, 2024, through, August 21, 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 5 resident(s); 5 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 21, 2024, issued for SL35562015-0, tag identification 0820. On September 2, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	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 Subd 1 (13) (i) (B) Minimum requirements	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 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 20, 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			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650			

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0 650	Continued From page 2 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 included all required content for two of two employees (unlicensed personnel (ULP)-C and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C	0 650			

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0 650	Continued From page 3 ULP-C began employment on December 24, 2019 to provide direct care services to residents. On August 20, 2024, at 1:00 p.m., the surveyor observed ULP-C administer R3's medications. ULP-E ULP-E began employment on October 24, 2022 to provide direct care services to residents. ULP-C and ULP-E's employee records lacked the following: - documentation of a current annual performance review that identified areas of improvement needed and training needs. On August 21, 2024, at 11:15 a.m., housing manager (HM)-A stated the annual performance review is done verbally with the employees but they have just been having the employees sign a blank document titled performance review and have not documented the discussion, areas of improvement, or training needs. The licensee's Performance Evaluations 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. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650			

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0 660	Continued From page 4	0 660			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for 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, for one of two employees, (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 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).	0 660			

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0 660	Continued From page 5 The findings include: The licensee's TB facility risk assessment tool dated June 27, 2024, indicated the licensee had a low risk for TB. ULP-C began employment on December 24, 2019 to provide direct care to residents. On August 20, 2024, at 1:00 p.m., the surveyor observed ULP-C administer R3's medications. ULP-C's record contained a chest x-ray dated July 27, 2017, which indicated active tuberculosis cannot be excluded at this time. ULP-C's record also lacked evidence of a TB baseline screening which included a two -step tuberculin skin test (TST) or other blood test with a positive result, to indicate the need for the chest x-ray. On August 21, 2024, at 11:58 a.m., housing manager (HM)-A stated ULP-C's employee file did not contain evidence of a positive TB test to indicate the need for the chest x-ray and did not realize the chest x-ray results did not rule out active TB. The licensee's 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. This includes, at a minimum, the health symptom screening, TB skin testing via the Mantoux method. This testing includes the pre-placement evaluation, administration And interpretation of TB Mantoux skin tests and periodic evaluation based on facility risk assessment or a negative IGRA (blood test).	0 660			

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0 660	Continued From page 6 The MDH resources and frequently asked questions, updated April 3, 2024, indicated a chest x-ray alone is not acceptable documentation. You either need: - Documentation of a positive two-step TST or IGRA test, and - A chest x-ray with provider evaluation after that date or - Documentation of refusal of both the two-step TST and IGRA - Followed by a new chest X-ray and provider evaluation. If the health care worker had a positive TB test result, and they only have the chest X-ray but no other test documentation, then they need to take a new TB test. If the result is positive, a new chest X-ray needs to be completed. The chest X-ray needs to be done within 90 days of the positive test date or dated any time after the positive test date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680			

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0 680	Continued From page 7 (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 and failed to post an EPP prominently. This had the potential to affect all residents, employees, and visitors to 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 the residents). The findings include: On August 19, 2024, housing manager (HM)-A stated she will email the EPP to me because she	0 680			

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0 680	Continued From page 8 was unable to find the binder and thinks it must have been removed by another staff member to be updated. The licensee's emergency preparedness plan (EPP) lacked the required content: - missing resident quarterly review; - description of the population served by licensee; - the development of policies/procedures to address: - subsistence needs for staff and residents; - procedures for tracking staff and residents; - procedures for medical documents; - use of volunteers; - arrangement with other facilities; and - roles under a waiver declared by Secretary. - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - primary and alternate means of communicating with: facility staff and Federal, State, tribal, reginal & local emergency management agencies; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to providing information about the facility's occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their family/representatives; - develop and maintain EP training and testing program; and - must conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP.	0 680			

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0 680	Continued From page 9 On August 21, 2024, HM-A stated they agreed the EPP binder was not on site, it was missing some of the required content and was not aware of the missing person policy needing to be reviewed on a quarterly basis. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility will have identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 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			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in	0 780			

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0 780	Continued From page 10 the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 780			

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0 780	Continued From page 11 On August 21, 2024, at 12:30 p.m., survey staff toured the facility with house manager (HM)-A. During the tour, HM-A tested smoke alarms installed in the facility. The surveyor observed when smoke alarms were tested on the main floor level of the home, these alarms did not actuate any of the other smoke alarms installed in the dwelling unit. The smoke alarm in resident occupied bedroom 2 did not work. During the facility tour interview on August 21, 2024, HM-A, verified the dwelling unit smoke alarms were not interconnected as required by statute and the smoke alarm in bedroom 2 was not working properly. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 790			

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0 790	Continued From page 12 failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 August 21, 2024, at 12:30 p.m., survey staff toured the facility with house manager (HM)-A. During the tour, the surveyor observed the following: 1. Monthly portable fire extinguisher inspections had not been completed. The back of the tags attached to the portable fire extinguishers were blank. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. 2. Portable fire extinguishers were not properly installed in the following locations: a. The fire extinguisher in the basement was mounted with the top of the extinguisher measuring 65 inches above the floor. b. The dining room fire extinguisher was mounted with the top of the extinguisher measuring 66 inches above the floor. All fire extinguishers provided in the facility must be properly maintained. Portable fire	0 790			

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0 790	Continued From page 13 extinguishers must be installed at least 4 inches off the ground up to a maximum of 5 feet (the top of the fire extinguisher to be no more than 5 feet above the ground). During the facility tour interview on August 21, 2024, HM-A verified the fire extinguishers were not properly installed and maintained. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800			

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0 800	Continued From page 14 or has the potential to affect a large portion or all of the residents). The findings include: On August 21, 2024, at 12:30 p.m., survey staff toured the facility with house manager (HM)-A. During the tour, the surveyor observed the following: 1. In the basement laundry room, there was standing water on the floor, sections of the floor had black soiling on the surface. The drywall on one of the walls was wet with black soiling on the lower section. 2. In the basement resident bathroom: a. On the wall near the door, one section of drywall was bubbled and noted as damp. b. Base tile was missing along the floor/wall transition. c. One section of the wall had been patched but not sealed or finished. d. The grab bar above the sink vanity was loose. e. One light bulb was not working in the fixture above the sink vanity. f. One tile was missing from the bathtub surround. g. Tape was installed on one side of the bathtub surround. During the facility tour interview, HM-A stated they did not know why this tape had been installed. h. The door trim was loose. 3. In occupied resident bedroom 4: a. An extension cord was used for the television, creating a fire hazard. b. Knobs or handles were not installed on the closet door. c. Sections of base trim were missing at the floor/wall junction. 4. In occupied resident bedroom 2, sections of	0 800			

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0 800	Continued From page 15 base trim were missing and/or loose at the floor/wall junction. 5. In occupied resident bedroom 1, the cover was not installed on the vent, and sections of floor trim were missing at the floor/wall junction. 6. The drywall finish was torn on one section of the wall in the basement recreation room. 7. In the main floor resident bathroom: a. The handle was loose for the sliding pocket door. b. The trim for the pocket door was broken. c. Knobs or handles were missing from the sink vanity doors. d. Three light bulbs were not working in the fixture above the sink. e. There were areas on the wall where finishes were not installed. 8. On the exterior of the facility: a. One downspout on the back of the home was broken. Downspouts that are not properly installed will not direct roof water away from the home. b. The cover was missing from the light fixture installed at the front door. c. There was a cabinet in disrepair stored on the back deck of the home. During the facility tour interview on August 21, 2024, HM-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810			

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0 810	Continued From page 16 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 drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan (FSEP) with the required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff,	0 810			

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0 810	Continued From page 17 and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 21, 2024, at 12:30 p.m., survey staff toured the facility with house manager (HM)-A. During the tour, the surveyor observed resident sleeping rooms were identified by numbers posted at the bedroom doors. The posted FSEP floor plans did not identify resident sleeping rooms by number. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview, HM-A verified the resident sleeping rooms were not identified. On August 21, 2024, at 2:30 p.m., survey staff requested the FSEP, training, and drill records. HM-A explained the owner would need to provide the FSEP and training records and this information would be emailed to the surveyor. The FSEP was not readily available within the facility. As of August 26, 2024, the FSEP and training records were not received. FIRE SAFETY AND EVACUATION PLAN The posted emergency floor plans failed to include the number of resident sleeping rooms.	0 810			

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0 810	Continued From page 18 Record review of the available documentation indicated the licensee had not developed and maintained a facility FSEP with employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by no documentation to support this had been completed. Record review of the available documentation indicated the licensee had not developed and maintained a facility FSEP with specific fire protection procedures for residents evident by no documentation to support this had been completed. Record review of the available documentation indicated the licensee had not developed and maintained a facility FSEP with specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by no documentation to support this had been completed. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by the lack of training documentation. No training records were provided to support employee training on the facility FSEP had been completed. Record review of the available documentation indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. No resident training records were provided for review.	0 810			

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0 810	Continued From page 19 DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by the lack of documentation to support evacuation drills had been performed at the required frequency. No evacuation drill records were provided for 2023. 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 commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect two residents and all staff. This practice resulted in a level three violation (a	0 820			

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0 820	Continued From page 20 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 21, 2024, at 12:30 p.m., survey staff toured the facility with housing manager (HM)-A. The egress windows in resident bedrooms were opened by HM-A and measured by the surveyor. The egress windows in resident bedrooms 2 and 4 did not meet the minimum requirements for safe egress. Egress window measurements: Bedroom 2 occupied by R3 - the clear open area of the window measured 17 3/4 inches width, 38 inches height, with a total clear area of 674.5 square inches. Bedroom 4 occupied by R4 - the clear open area of the window measured 20 1/2 inches width, 15 inches height, with a total clear area of 307.5 square inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). During the facility tour interview, HM-A verified the egress window measurements.	0 820			

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0 820	Continued From page 21 TIME PERIOD FOR CORRECTION: Immediate On August 21, 2024, at 12:30 p.m., survey staff toured the facility with housing manager (HM)-A. During the tour, the surveyor observed door locking hardware installed at the top of the bedroom doors for occupied resident rooms 1 and 4. These locks used a bolt that required pulling down on a chain to unlock the door when exiting the room. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. Door latching hardware is required to be located not higher than 48" from the floor. TIME PERIOD FOR CORRECTION: Two (2) days	0 820			
01370 SS=D	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;	01370			

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01370	Continued From page 22 (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: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees unlicensed personnel (ULP)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01370			

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01370	Continued From page 23 The findings include: ULP-E was hired to provide direct care services for the licensee on October 24, 2022. ULP-E's employee record lacked the following training and competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. On August 21, 2024, at 2:20 p.m., housing manager (HM)-A stated they agreed ULP-E's employee record was missing some of the required competency evaluations, but they may be in another file. The surveyor received more training and competency records for ULP-E, but they did not include the above listed topics. The licensees Competency Evaluations policy indicated training and competency evaluations for all unlicensed personnel must include the following: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			

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01380	Continued From page 24	01380			
01380 SS=D	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: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees unlicensed personnel (ULP)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01380			

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01380	Continued From page 25 The findings include: ULP-E was hired to provide direct care services for the licensee on October 24, 2022. ULP-E's employee record lacked the following training and competency evaluations: - reading and recording temperature, pulse, and respirations of the client. On August 21, 2024, at 2:20 p.m., housing manager (HM)-A stated they agreed ULP-E's employee record was missing some of the required competency evaluations, but they may be in another file. The surveyor received more training and competency records for ULP-E, but they did not include the above listed topic. The licensees Competency Evaluations policy indicated training and competency evaluations for all unlicensed personnel must include the following: - reading and recording temperature, pulse, and respirations of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:	01500			

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01500	Continued From page 26 (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), 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	01500			

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01500	Continued From page 27 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees unlicensed personnel (ULP)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-E began employment on October 24, 2022 to provide direct care services to residents. ULP-E's record lacked evidence annual training had been completed as required in the following areas: - Reporting maltreatment of vulnerable adults or minors; and - Review of provider's policies and procedures. On August 21, 2024, at 2:20 p.m., housing	01500			

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01500	Continued From page 28 manager (HM)-A stated she agreed ULP-E's employee record was missing some of the required annual training topics. The licensee's Annual Training Requirements policy indicated annual training must include: - Training on reporting of maltreatment of vulnerable adults under section 626.557; - Review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Review of infection control techniques used in the home and implementation of infection control standards; - Effective approaches to use to problem solve when working with a residents challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease or related disorders; - Review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
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	01760			

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01760	Continued From page 29 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 document the reason why medication administration was not completed as prescribed and failed to document any follow-up procedures that were provided to meet the residents needs when medication was not administered as prescribed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 was admitted on February 6, 2020, and began receiving assisted living services on August 1, 2021. On August 19, 2024, at 12:125 p.m., the surveyor observed unlicensed personnel (ULP)-C provide	01760			

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01760	Continued From page 30 meal assistance for R2. R2's service plan dated August 5, 2024, indicated R2 received assistance with dressing, bathing, behavior management, medication administration, meal assistance, toileting, transfer assist, laundry and housekeeping. R2's physician orders signed June 23, 2024, indicated R2 was prescribed the following medications: -levetiracetam 750 mg tablet. Take 1 tablet by mouth two times daily. Diagnosis: seizure -cholecalciferol 1,000 unit capsule. Take 1,000 units by mouth once daily. Diagnosis: Vitamin D deficiency -clozapine 200 mg tablet. Take 1 tablet by mouth at bedtime. Diagnosis: schizophrenia -ferrous sulfate 325mg tablet. Take 1 tablet by mouth once daily with a meal. Diagnosis: anemia -gabapentin 100mg capsule. Take 100mg by mouth two times daily. Diagnosis: nerve pain -mometasone-formoterol 200-5 micrograms (mcg). Inhale 2 puffs by mouth two times daily. Diagnosis: chronic obstructive pulmonary disease -omeprazole 20 mg capsule. Take 1 capsule by mouth two times daily before meals. Diagnosis: nausea and vomiting -prazosin 1 mg capsule. Take 1 mg by mouth at bedtime. Diagnosis: high blood pressure -sertraline 100 mg tablet. Take 100mg by mouth once daily. Diagnosis: depression -simvastatin 10 mg tablet. Take 10mg by mouth at bedtime. Diagnosis: elevated cholesterol -sucralfate 100 mg/milliliter (mL). Take 1,000mg by mouth four times daily after meals and at bedtime. Diagnosis: gastro-esophageal reflux disease (heartburn) -tiotropium 18 mcg inhalation capsule. Inhale 18mcg by mouth once daily. Diagnosis: chronic	01760			

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01760	Continued From page 31 obstructive pulmonary disease R2's medication administration record (MAR) dated August 1, 2024, through August 19, 2024, for sucralfate 100mg/milliliter (mL) administration time of 12:00 a.m. and 6:00 a.m., lacked documentation that medication administration was completed on August 1, 2, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 16. The MAR lacked documentation of the reason the medication was not administered. R2's MAR dated August 1, 2024, through August 19, 2024, for ferrous sulfate 325mg administration time of 8:00 a.m., indicated the medication was not administered on August 1-7 and 10-19. The MAR indicated the medication was not administered due to being out of stock and nurse was notified. R2's MAR dated August 1, 2024, through August 19, 2024, for tiotropium 18 mcg administration time of 8:00 a.m., indicated the medication was not administered on August 4-11 and 13-18. The MAR indicated the medication was not administered due to being out of stock and nurse was notified. R2's Resident Notes dated July 1, 2024 through August 19, 2024, lacked documentation of follow-up procedures that were provided to meet the residents needs when medication was not administered as prescribed. On August 21, 2024, at 2:05 p.m., clinical nurse supervisor (CNS)-B stated she did not realize the MAR was missing some documentation and had called the pharmacy asking for a refill on the medications out of stock, but they could not refill them without a new order from R2's primary care	01760			

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01760	Continued From page 32 physician. CNS-B stated she contacted the primary care physician office and they were requiring an appointment, an appointment was scheduled but did not document any of this information anywhere in the resident record. The licensee's Medication Management Services policy indicated the RN or LPN will review each resident's medication record when the nurse is setting up medications and at other appropriate times based on the resident's needs and the resident's medication management services, including during the resident monitoring visit: -to verify that staff is administering the medications as prescribed and is documenting the administration appropriately with authentication by each staff person by discipline or title; -to review and evaluate the administration of PRN medications; -to observe for signs of medication diversion; and -to evaluate the effectiveness of the medications and identify any drug to drug interaction, and unwanted or reported side effects. Any the issues or concerns will require follow up and documentation by the nurse, including communications with the prescriber and pharmacy, education of the resident and/or the resident's representative, and additional training for staff or other appropriate actions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880			

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01880	Continued From page 33 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartments and permitted only authorized personnel to have access. 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 19, 2024, at 10:55 a.m., during entrance conference, housing manager (HM)-A stated all resident medications were stored and secured in the medication cart located in the dining room and they had a small refrigerator downstairs that contained a couple of medications. On August 19, 2024, at 12:00 p.m., during a tour of the facility, the surveyor observed the medication refrigerator located downstairs in the common area, the refrigerator did not have a locking mechanism and was accessible to all staff, residents and visitors.	01880			

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01880	Continued From page 34 The medication refrigerator contained the following medications: - Victoza 0.6 milligram (mg) injection pen (noninsulin medication that lowers blood sugar)-one new pen; and - latanoprost 0.005% ophthalmic solution (eye drop)- two bottles. On August 19, 2024, HM-A stated they are thinking of putting up a wall and door to create a lockable room that the medication refrigerator can be placed in, so it will be locked, but currently the refrigerator does not lock. On August 20, 2024, at 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-C use the medication cart located in the dining room area to administer R3's medications. The medication cart was unlocked, the lock mechanism on the cart was broken and the cart was accessible to all staff, residents and visitors. On August 20, 2024, at 1:25 p.m., HM-A stated the medication cart was broken and needed to be fixed, so currently the medication cart cannot be locked. On August 21, 2024, at 2:05 p.m., clinical nurse supervisor (CNS)-B stated she would expect all medications to be locked and secured. The individualized medication management plans for R2 and R3 both indicated all uncontrolled medications will be secured in a locked medication cabinet and given to the resident as scheduled. The licensee's Individualized Medication Management Plan and Record policy indicated	01880			

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01880	Continued From page 35 the RN develops an individualized medication management record for the resident in conjunction with the resident and/or the residence representative. The plan must include the following: -description of how medications will be stored, based on the residents needs, risk of diversion and consistent with the manufacturer's directions. The RN asks the resident and/or the residents representative to sign modifications to the medication management plan when: -there is a change in how the medications will be stored. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940			

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01940	Continued From page 36 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 21, 2024, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-C and clinical nurse supervisor (CNS)-B providing catheter care and changing R3's catheter. R3 was admitted on July 29, 2021, and began	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35562	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER EMPIRE SYSTEMS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3301 LAWRENCE ROAD BROOKLYN CENTER, MN 55429		
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01940	Continued From page 37 receiving assisted living services on August 1, 2021. R3's diagnoses included traumatic brain injury, diabetes type 2, paraplegia, seizure disorder, anxiety, and adjustment disorder. R3's Service Plan dated May 23, 2024, indicated R3 received assistance with catheter care, dressing, bathing, behavior management, medication administration, meal assistance, toileting, transfer assist, laundry and housekeeping. R3's Individualized Treatment and Therapy Plan dated July 4, 2024, failed to include: -documentation of specific resident instructions relating to the treatment or therapy administration; and -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. The licensee's Treatment and Therapy Management Plan policy indicated when the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: -a written statement of the treatment or therapy that will be provided; -documentation of specific instructions that relate to providing the treatment or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and -procedures for notifying a registered nurse or other licensed health professional if problems	01940			

Minnesota Department of Health

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01940	Continued From page 38 arise with the treatment or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards related to secure oxygen tank storage and hospital bed rails for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: SECURE OXYGEN TANK STORAGE On August 19, 2024, at 10:55 a.m., during the	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35562	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2024
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02310	Continued From page 39 entrance conference, the surveyor observed one single oxygen tank located in the dining room standing upright on the floor. The oxygen tank was not secured in a noncombustible rack. On August 19, 2024, at 12:00 p.m., during a tour of the facility, the surveyor observed a second single oxygen tank located near the front door entryway. The oxygen tank was not secured in a noncombustible rack. On August 19, 2024, at 12:00 p.m., when asked about the unsecured oxygen tanks, HM-A stated the tanks should be empty and just need to be picked up by the oxygen company. HM-A placed both oxygen tanks on top of other items already stored in the floor of a closet located in the front door entryway. On August 19, 2024, during the tour of the facility, the surveyor observed R2's bedroom which contained four single oxygen tanks, that were full of oxygen and were sitting on the floor beside an oxygen concentrator. The tanks were not secured in a noncombustible rack. On August 19, 2024, at 12:00 p.m., HA-A stated she was not aware that oxygen tanks needed to be securely stored in a rack. On August 21, 2024, at 2:05 P.M., clinical nurse supervisor (CNS)-B stated she would expect oxygen tanks to be securely stored in a rack. The licensee's Safe Oxygen Use and Storage policy indicated the RN or oxygen representative will educate staff to be alert to any safety concerns related to the use and storage of oxygen, consistent with the manufacturer's instructions. Staff will be trained to reinforce the	02310			

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02310	Continued From page 40 resident of a safety concern, take steps to eliminate the danger as quickly as possible, and report to the RN any use or storage of oxygen that is inconsistent with the manufacturer's directions and with the following guidelines: -containers must be stored in a well-ventilated area and should not be kept under a bed, in a small area such as a closet or cabinet or covered by linens or clothing. -containers must be secured in a stand or cart so they cannot be knocked over while in use or in storage and must not be in areas where they may be overturned due to a door opening or where they are in a pathway. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. HOSPITAL BED RAILS On August 19, 2024, at 12:00 p.m., during a tour of the facility, the surveyor observed R2's bed rails attached to her hospital bed. R2 was admitted to the licensee on February 6, 2020, and began receiving assisted living services on August 1, 2021. R2's diagnoses include paranoid schizophrenia, asthma, dysphagia, anxiety and depression. R2's service plan dated August 4, 2024, indicated R2 received assist with oxygen management, transfers, dressing, bathing, medication	02310			

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02310	Continued From page 41 administration, meal assistance, toileting, laundry and housekeeping. R2's Bed Safety Assessment dated May 31, 2024, included: - an assessment; - the rails were FDA compliant; and - the risk vs. benefit were discussed and documented with the resident. R3's assessment lacked: - measurements that were completed and documented. On August 20, 2024, at 11:40 a.m., CNS-B stated the bed rail assessment was missing the specific measurements and she did not realize they were needed but will add them to the assessment. The licensee's Use of Side Rail policy indicated the RN will assess and evaluate what the residents needs are and if the resident's can safely utilize the side rail/equipment. Assessment will determine whether the equipment meets the FDA standards for side rails. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail	02310			

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02310	Continued From page 42 has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			

Type: Full
Date: 08/20/24
Time: 17:20:03
Report: 1018241121

Food and Beverage Establishment Inspection Report

Page 1

Location:

Empire Systems Home Care
3301 Lawrence Road
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038929
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632257396
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.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

CABINET DOORS THROUGHOUT THE KITCHEN WERE OBSERVED TO BE BROKEN AND HANGING OFF THE HINGES. DISCUSSED WITH MANAGER TO HAVE THESE ITEMS REPAIRED.

Comply By: 08/30/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

EVIDENCE OF PAST RODENT ACTIVITY VIEWED IN THE KITCHEN. OLD MOUSE TRAPS OBSERVED UNDER COUNTERS. DISCUSSED WITH MANAGER TO CLEAN OLD MOUSE DROPPINGS, REMOVE OLD TRAPS, AND CALL PEST CONTROL FOR NEW ASSESSMENT OF THE AREA.

Comply By: 08/23/24

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

INSPECTION CONDUCTED WITH SARABETH REMKER (MDH) PRESENT

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT, RESIDENTIAL CABINETS/COUNTER TOPS, AND RESIDENTIAL STYLE FLOORS, WALLS AND CEILINGS. ALL APPEAR TO BE IN GOOD CONDITION.

Type: Full
Date: 08/20/24
Time: 17:20:03
Report: 1018241121
Empire Systems Home Care

Food and Beverage Establishment Inspection Report

Page 2

ESTABLISHMENT HAS A DISHWASHER THAT HAS A SANITIZE FUNCTION AVAILABLE FOR DISHES.

SINK HAS TWO COMPARTMENTS THAT ARE DESIGNATED ONE FOR HAND WASHING AND ONE FOR RINSING DISHES.

ESTABLISHMENT DOES ALL SAME DAY FOOD SERVICE FOR CLIENTS, AND NO LEFTOVERS ARE SAVED.

DISCUSSED EMPLOYEE ILLNESS REPORTING AND ILLNESS LOGS.

DISCUSSED PEST CONTROL MANAGEMENT.

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

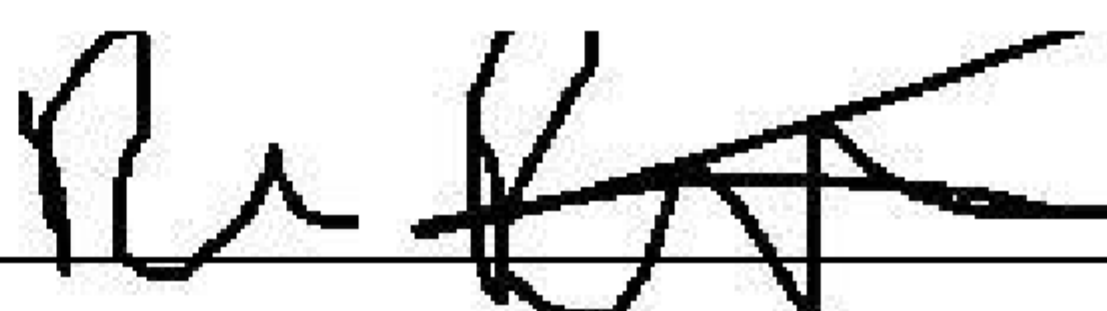
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018241121 of 08/20/24.

Certified Food Protection Manager EMMANUEL R WHEAGAR

Certification Number: FM108016 Expires: 08/28/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed:  _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us