



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 7, 2025

Licensee
Empowerment Healthcare
112005 Hidden Creek Place
Chaska, MN 55318

RE: Project Number(s) SL20957015

Dear Licensee:

On December 3, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 18, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

October 17, 2024

Licensee
Empowerment Healthcare
112005 Hidden Creek Place
Chaska, MN 55318

RE: Project Number(s) SL20957015

Dear Licensee:

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

STATE CORRECTION ORDERS

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

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 "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20957015 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to post a daily work schedule that clearly identified the staff scheduled for the facility. In addition, the facility failed to develop a staffing plan that included metrics to determine staffing levels to meet the scheduled and unscheduled needs of all residents. This had the potential to affect the current residents, staff, and visitors.	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for five residents and had a current census of three residents. The facility was attached to another assisted living facility, owned by the same licensee, separated by a door. The licensee also owned the building next door to this facility, with two facilities separated by a door. Each of the four assisted living facilities had their own Health Facility Identification number (HFID); one staff was assigned to provide services to the residents who resided in each in the two attached facilities. DAILY WORK SCHEDULE On September 16, 2024, at 12:30 p.m., during a tour of the facility with licensed assisted living director residency (LALDR)-B the surveyor observed a staffing schedule posted on the wall inside HFID 20957. On the other side of the kitchen/dining/common area was a door that could be locked, that was open at the time of the tour, which led into HFID 20396. The schedule was titled [development name, a group of four assisted living facilities owned by the licensee] was color coded and dated Monday September 9, 2024, through September 21, 2024. September 16, 2024's, date included six names and the shifts noted were:	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 - 7:00 a.m. through 5:00 p.m. (red) - 7:00 a.m. through 3:00 p.m. (yellow) - 3:00 p.m. through 11:00 p.m. (red) - 5:00 p.m. through 11:00 p.m. (red) - 11:00 p.m. through 7:00 a.m. (yellow) - 11:00 p.m. through 7:00 a.m. (green). The schedule did not identify the facility that coincided with each color. On September 16, 2024, at 1:31 p.m., unidentified unlicensed personnel (ULP) stated the ULPs no longer used the color-coded system for work assignment, "ULPs worked where they wanted to work." On September 16, 2024, at 1:36 p.m., LALDR-B stated ULPs should be following the color-coded system for staff assignment and provided the surveyor with a piece of paper that indicated the color on the schedule and which facility the color coincided with. LALDR-B stated the staff scheduled for this facility also provided services for the residents in the attached facility. Although the daily work schedule was posted, staff were not following the schedule by working in their assigned facility, and there was no indication of what color coincided with which facility. On September 16, 2024, at 1:36 p.m., LALDR-B stated ULPs should be following the color-coded system for staff assignment and provided the surveyor with a piece of paper that indicated the color on the schedule and which facility the color coincided with. LALDR-B stated the staff scheduled for this facility also provided services for the residents in the attached facility. Although the daily work schedule was posted,	0 470			

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0 470	Continued From page 4 staff were not following the schedule by working in their assigned facility, and there was no indication of what color coincided with which facility. STAFFING PLAN On September 16, 2024, at 1:41 p.m., LALDR-B reviewed the facility staffing plan with the surveyor. -(name) of house was staffed at a one to six ratio (house licensed for five residents) *house is staffed 24 hours a day seven days a week *all staff are always awake *all staff are to always remain on site during shift *summoning device provided to clients to call staff to quickly respond efficiently *nurse and managers on call 24/7 for emergencies. -full time staff work Monday through Friday *7:00 a.m., -3:00 p.m., house manager shift *3:00 p.m., - 11:00 p.m., direct care staff *11:00 p.m., -7:00 a.m., direct care staff -part time staff work weekends (Saturday and Sunday) *7:00 a.m., -3:00 p.m., direct care staff *3:00 p.m., -11:00 p.m., direct care staff *11:00 p.m., 7:00 a.m., direct care staff. -emergency staffing steps: *pull staff from another facility; if not available *utilize staffing agency; if not available *contact DHS (department of human services) for emergency staffing. LALDR-B explained there was no part time staff on the weekends, but the staff who worked for the licensee could be part time staff. LALDR-B added	0 470			

Minnesota Department of Health

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0 470	Continued From page 5 the "house manager shift" was for a direct care staff. LALDR-B stated the nurse (clinical nurse supervisor (CNS)-C) developed the staffing plan, "they talk" (LALDR-B and CNS-C). LALDR-B stated she was not aware of any metrics used to determine the staffing requirements. The staffing plan included: LALD, human resource manager, and "nurses" met on August 30, 2024. On September 17, 2024, at 6:30 a.m. ULP-I stated she "covers" (works) both facilities (two HFID) at the same time and the door is "always open." The licensee had a previous staffing plan dated December 1, 2023, which was the same of the staffing plan dated August 1, 2024. The staffing plan lacked information to include the one staff per shift also provided services to the residents in the attached facility, which also currently included three residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. During an interview on September 18, 2024, 10:08 a.m., CNS-C stated she looked at the	0 470			

Minnesota Department of Health

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0 470	Continued From page 6 residents' needs when developing the staffing plan, and if a resident was not ambulatory or needed assistance with ambulation, or had an increase in behaviors, they would possibly need two staff to mitigate the issue. When asked about recent resident-to-resident altercations, CNS-C stated they would close and lock the door between the two facilities to keep residents safe; however, could not explain how residents' needs would be met if the staff was in the attached facility with the door locked. CNS-C stated the part-time weekend staff listed on the staffing plan were not "extra" staff, but could be hired as "part-time staff." CNS-C stated the licensee did not have evidence of an evaluation to determine the needs of the residents to ensure that staffing levels were adequate to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy, reviewed January 3, 2022, indicated the clinical nurse supervisor would develop a 24-hour daily staffing schedule to include direct care staff work schedules for each direct care staff member, indication of all work shifts, including days and hours worked, and identify direct care staff member's resident assignments or work location. The posted daily work schedule would be posted in each building	0 470			

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0 470	Continued From page 7 of a facility or campus accessible to staff, residents, volunteers, and the public. The policy also directed a clinical nurse supervisor, or designee, would develop, write, and implement a staffing plan that would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven days a week, and would be adequate to address: - each resident's needs as identified in the service plan and assisted living contract; - each resident's acuity level as determined by the most recent assessment or individualized review; - ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises; and - staff competency and training. The staffing plan would be evaluated for the appropriateness of the staffing levels in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480			

Minnesota Department of Health

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0 480	Continued From page 8 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 September 16, 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			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and	0 490			

Minnesota Department of Health

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0 490	Continued From page 9 (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs posted and available to residents and visitors. This had the potential to affect three residents of 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 September 16, 2024, at 11:25 a.m., during the entrance conference with licensed assisted living director in residency(LALDR)-B, owner/agent (OA)-A, and licensed practical nurse (LPN)-G stated the licensee provided culturally sensitive programs and provided a daily program of social and recreational activity. On September 18, 2024, at 9:31 a.m., the surveyor observed and reviewed an activity calendar posted in the open common area with unlicensed personnel (ULP)-H. ULP-H stated she	0 490			

Minnesota Department of Health

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0 490	Continued From page 10 had not seen that activity calendar prior to now, adding the activity calendar must be new. ULP-H reviewed the undated activities calendar with the surveyor: -Sunday: read the paper, current events -Monday: cards -Tuesday: crafts, coloring, painting -Wednesday: crossword, word search -Thursday: board games -Friday: movie night -Saturday: puzzles. The events were listed six times (weeks), duplicated. ULP-H said the activities listed were not "geared for them (residents) adding, they (residents) are considered independent and added music in the park would be a good activity for the residents. ULP-H stated R5 (diagnosis dementia) might do the crossword and word search if a staff assisted R5. On September 18, 2024, at 9:45 a.m., R3 stated, "my depression comes really quick, and it happens because we don't do anything." R3 said about four months ago they (residents) went to Perkins, and he enjoyed that and added some went to the state fair (residents from this location and three other locations owned by the same owner). On September 18, 2024, at 10:49 a.m., LALDR-B stated the licensee recently lost a staff, the house manager and she (house manager) saw to several activities, including birthday parties. LALDR-B acknowledged the licensee missed a birthday party of a resident the day prior adding she (LALDR-B) felt bad about that. The licensee's Residents Activities policy dated January 3, 2024, noted recreational opportunities	0 490			

Minnesota Department of Health

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0 490	Continued From page 11 would be offered based on the interests of the residents. The assisted living statue requires that a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large was offered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed by one of two unlicensed personnel (ULP)-F while providing assistance to residents. This practice resulted in a level two violation (a	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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0 510	Continued From page 12 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on June 13, 2022, to provide direct care services to the facility's residents. ULP-F's employee record included: -OSHA (Occupational Safety and Health Administration) and infection control education completed April 14, 2024. On September 17, 2024, at 8:24 a.m., the surveyor observed R2 seated at the dining room table. There was a plate of food sitting near R2; an egg sandwich (two pieces of bread, eggs in the middle) and cantaloupe. ULP-F went to get a cup of water from the kitchen. ULP-F handed R2 a small black case. R2 opened the case that contained a blood glucose meter, testing strips, wipes, lancet pen. ULP-F without gloves on, removed the lancet pen (devious used for making a small incision) and handed it to R2. ULP-F applied gloves; the surveyor did not observe ULP-F perform hand hygiene prior to glove application. ULP-F asked R2 if he was ready? ULP-F stated, let me (ULP-F) wipe your (R2's) hands. ULP-F chose R2's left pinky finger, cleaned the area, removed a blood testing strip out of a container and put the strip into the blood glucose testing monitor. R2 used the lancet and squeezed his pinky finger to obtain a drop of blood. ULP-F applied the droplet of blood onto the	0 510			

Minnesota Department of Health

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0 510	Continued From page 13 testing strip to obtain a reading of 186. ULP-F removed the gloves and handed R2 a previously prepared medication cup of medications. ULP-F placed the blood glucose meter and lancet pen back into the case. R2 poured the medications onto the table. ULP-F asked R2 to put the medication back into the cup. R2 took the medication. ULP-F picked up the prepared plate that was positioned near R2 and placed the plate of food in front of R2. ULP-F went to the kitchen to get a cup of coffee for R2. ULP-F placed the cup of coffee into the microwave, and then took the coffee to R2 once the coffee had been heated. ULP-F went to R5's doorway to announce breakfast was ready. The surveyor did not observe ULP-F perform hand hygiene after checking R2's blood glucose level, before handing R2 his morning medication, repositioning R2's breakfast, or getting R2 coffee. On September 17, 2024, at 8:34 a.m., ULP-F stated she forgot to perform hand hygiene, "got busy." On September 17, 2024, at 8:35 a.m., ULP-F used hand sanitizer. On September 17, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-C stated hand hygiene should consist of cleaning hands when gloves are removed. CNS-C added a paper towel should have been placed on the table in front of R2 also. CNS-C confirmed infection control measures were not completed per her expectations or training. The licensee's Hand Hygiene policy dated January 3, 2022, noted hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes	0 510			

Minnesota Department of Health

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0 510	Continued From page 14 place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: -before and after direct contact with a resident -if moving from a contaminated-body site to a clean-body site during resident care -after contact with environmental surfaces or equipment in the immediate vicinity of the resident -after removing gloves or gowns. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680			

Minnesota Department of Health

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0 680	Continued From page 15 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 observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) posted in a prominent area and developed with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 16, 2024, at 12:02 p.m., during the entrance conference licensed assisted living director in residency (LALDR)-B stated the facility's EPP was in a red binder, in the medication cart in the laundry room, or medication room, in each building (two health facility identification number (HFID) facilities connected by a lockable door.) On September 16, 2024, at 12:33 p.m., during a tour of the facility LALDR-B stated there was not an EPP binder in "this" (HFID 20957) facility. Two red EPP binders were located in a locked room in	0 680			

Minnesota Department of Health

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0 680	Continued From page 16 HFID 20396. Owner/agent (OA)-A stated the location of the EPP would be corrected before "we" leave. The licensee's EPP last reviewed January 31, 2024, failed to include the following: - a missing resident plan that was reviewed quarterly - procedures for tracking of staff and residents. On September 16, 2024, at 3:04 p.m., OA-A noted via an email that the missing person policy was reviewed annually. On September 16, 2024, at 3:17 p.m., OA-A noted via an email the licensee did not have a complete strategy of tracking on duty staff and residents as required. The licensee's Emergency and Disaster Preparedness policy reviewed July 1, 2023, noted our facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.F 483.73 (c). A written policy and procedure regarding missing residents was complete in compliance with MN Rule 4659.0110. In addition, the facility will post the emergency disaster plan prominently. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness	0 680			

Minnesota Department of Health

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0 680	Continued From page 17 regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730			

Minnesota Department of Health

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0 730	Continued From page 18 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the resident record included documentation of a smoking assessment for two of two residents (R3, 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	0 730			

Minnesota Department of Health

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0 730	Continued From page 19 a large portion or all of the residents). The findings include: R3 R3 was admitted for services on August 29, 2023. R3's diagnoses included major depressive disorder, traumatic brain injury, car accident at age 12, hypertension (HTN/high blood pressure), diabetes, gastro-esophageal reflux disease (GERD/stomach acid), and arthritis. R3's service plan dated March 17, 2024, indicated R3 received medication administration or assistance with self-administration, mental health management (with orientation, anxiety, depression) and housekeeping services. R3's assessment dated August 20, 2024, noted: -indicate history or current use of tobacco products: current active smoker -indicate assistance needed to smoke safety: independent. On September 17, 2024, at 6:51 a.m., the surveyor observed R3 go outside with a cigarette in R3's mouth. R3 was not outside very long before he re-entered the facility. R3 stated he only needed "three drags and I (R3) am done; I am trying to quit." R2 R2 was admitted for service on April 15, 2022. R2's diagnoses included diabetes, traumatic brain injury, HTN, and depressive episodes. R2's service plan dated April 13, 2023, indicated R2 received assistance dressing, grooming,	0 730			

Minnesota Department of Health

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0 730	Continued From page 20 bathing, continence care, assistance walking, medication administration, orientation management, and housekeeping services. R2's assessment dated July 15, 2024, noted: -indicate history or current use of tobacco products: current active smoker -indicate assistance needed to smoke safely: independent. On September 17, 2024, at 8:40 a.m., R2 stated he was going outside to vape, adding he (R2) did not "think" vaping was so bad. On September 18, 2024, at 11:06 a.m., clinical nurse supervisor (CNS)-C stated she does a smoking assessment adding we (CNS-C and resident) talk about it (smoking), make sure they (resident is safe), storage of lighter etc. CNS-C stated the assessment piece was done but CNS-C confirmed the assessment was not in the resident's records. CNS-C said she would talk to the computer system used to add the smoking component into the assessment. CNS-C added some assessments are separate, but she could not find "a smoking assessment" in resident records. The licensee's Resident Records policy reviewed January 3, 2022, noted the resident record would contain documents relevant to the resident's services or status. The licensee's Initial and On-Going Nursing Assessment of Residents policy reviewed January 3, 2022, noted a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs would be completed. A comprehensive assessment included but may not be limited to the requirements outlined by	0 730			

Minnesota Department of Health

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0 730	Continued From page 21 Minnesota rules, to include: -smoking including the ability to smoke without causing burns or injury to the resident or others or damage to property. No further information provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 730			
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 maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 22 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 September 17, 2024, from 10:05 a.m. to 11:30 a.m., the surveyor toured the facility with maintenance staff (M)-D. The following was observed. The dining room fan and vent grille had a thick layer of dust and grease. M-D stated they had just cleaned the fan in the past year when they painted the facility. The light in the kitchen was missing the cover and had no light installed. The capped electrical wires were exposed to the kitchen. M-D stated he purchased the incorrect size of light tubes the day before, but was planning to buy the correct size replacement bulbs and get them installed by the end of the day. On September 17, 2024, at 11:30 a.m., M-D stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
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	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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0 820	Continued From page 23 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 ensure the physical facility elements did not constitute a distinct hazard to life. The licensee had door lock hardware on the egress side of the patio door leading outside. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. 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 September 17, 2024, from 10:05 a.m. to 11:30 a.m., the surveyor toured the facility with maintenance staff (M)-D. The patio door had a hotel-style door guard security latch at the top of the door. The patio door had been identified on the evacuation plans as an emergency exit and	0 820			

Minnesota Department of Health

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0 820	Continued From page 24 also had an emergency exit sign posted above the door. Required exit doors in this type of facility are allowed to be provided with one security type lock (2 locking devices total) such as the deadbolt, in addition to the door latch lock, and installed not more than 48 inches from the floor. On September 17, 2024, M-D stated they understood the exit doors could not have extra locks in addition to a standard latch and deadbolt with a thumb turn. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820			
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 900	Continued From page 25 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an interview on September 18, 2024, at 10:46 a.m., owner (O)-A stated an unsigned copy of the licensee's contract had not been sent to the Ombudsman as required. O-A stated, "We didn't do that." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 900			

Minnesota Department of Health

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0 900	Continued From page 26 (21) days	0 900			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and	01060			

Minnesota Department of Health

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01060	Continued From page 27 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R4). 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: R4's service plan dated September 1, 2023, indicated R4 received assistance with dressing, grooming, bathing, medication administration or assistance with self-administration, mental health management assistance, and homemaking services. Progress notes for R4 included: -November 15, 2023: "resident attacked two staff members today morning [sic] while he was being given his medications and breakfast, he threw the	01060			

Minnesota Department of Health

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01060	Continued From page 28 food down and pushed one staff member to get to the house manager who he pushed to the wall, then he removed his pants and exposed his manhood to her. He had been taken by the police to [hospital] ER (emergency room) in [name of city]." -November 28, 2023: "The following communication was sent to the Case Manager (name) on November 17, 2023. Given the serious nature of these assaults, we feel we are no longer able to care for him. Two of the staff are on medical leave per MD (medical doctor) instruction. Our staff fear him and will not work if he returns to our facility. Based on this we have reported to the hospital we will not be able to have him return. Following repeated phone calls and emails to the case manager as well as phone calls to their supervisor, no response received to date. We have struggled in receiving timely responses from (name), unanswered email and phone calls with no response. Effective today, name (R4) will be discharged from our facility." R4's record lacked a written notice that contained, at a minimum: -record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On September 17, 2024, at 9:51 a.m., clinical	01060			

Minnesota Department of Health

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01060	Continued From page 29 nurse supervisor (CNS)-C stated for R4 she did not complete all of the required notifications. CNS-C added it was an oversight on her part. CNS-C said there had been several assaults leading up to R4's relocation, and if R4 were to return several staff had stated they would quit. CNS-C stated she did not, "even think," he was discharged, adding she missed sending notifications as required. On September 17, 2024, at 3:53 p.m., CNS-C stated R4 was taken to the hospital by police after assaults on staff on November 15, 2023, due to these assaults and his escalating behavior the decision was made on November 17, 2023, to not have him return to the facility. CNS-C said she attempted several times to contact the case manager, but they never responded, and after exhausting those efforts, the licensee finally concluded R4's discharge on November 28, 2023. CNS-C confirmed the OOLTC had not been notified as required. The licensee's undated Contract Termination/Emergency Relocation policy noted in the event of an emergency relocation, the facility must provide a written notice that contained, at a minimum: -the reason for the relocation -the name and contact information for the location to which the resident had been relocate and any new service provider -contact information for the Office of Ombudsman for Long-Term Care -if know and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement tat a return date was not currently known, and -a statement that, if the facility refused to provide housing or services after a relocation, the	01060			

Minnesota Department of Health

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01060	Continued From page 30 resdient had the right to appeal under section 144G.54. The facility would provide contact information for the agency to which the resident may submit an appeal. The notice required would be delivered as soon as practicable to: -the resident, legal representative, and designated representative -for resdient's who receive home and community-based waiver services under the resident's case manger, and -the Office of Ombudsman for Long-Term Care if the resident had been relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee refused to allow a resident to return after a hospitalization without issuing a termination notice for one of one resident (R4). 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	01070			

Minnesota Department of Health

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01070	Continued From page 31 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: R4's service plan dated September 1, 2023, indicated R4 received assistance with dressing, grooming, bathing, medication administration or assistance with self-administration, mental health management assistance, and homemaking services. Progress notes for R4 included: -November 15, 2023: "resident attacked two staff members today morning [sic] while he was being given his medications and breakfast, he threw the food down and pushed one staff member to get to the house manager who he pushed to the wall, then he removed his pants and exposed his manhood to her. He had been taken by the police to [hospital] ER (emergency room) in [name of city]." -November 28, 2023: "The following communication was sent to the Case Manager (name) on November 17, 2023. Given the serious nature of these assaults, we feel we are no longer able to care for him. Two of the staff are on medical leave per MD (medical doctor) instruction. Our staff fear him and will not work if he returns to our facility. Based on this we have reported to the hospital we will not be able to have him return. Following repeated phone calls and emails to the case manager as well as phone calls to their supervisor, no response received to date. We have struggled in receiving timely responses from (name), unanswered email and phone calls with no response. Effective today,	01070			

Minnesota Department of Health

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01070	Continued From page 32 name (R4) will be discharged from our facility." R4's record lacked evidence to include a termination notice had been issued appropriately, prior to refusing the resident to return to the facility. On September 17, 2024, at 9:51 a.m., clinical nurse supervisor (CNS)-C stated for R4 she did not complete all of the required notifications. CNS-C added it was an oversight on her part. CNS-C said there had been several assaults leading up to R4's relocation, and if R4 were to return several staff had stated they would quit. CNS-C stated she did not, "even think," he was discharged, adding she missed sending notifications as required. On September 17, 2024, at 3:53 p.m., CNS-C stated R4 was taken to the hospital by police after assaults on staff on November 15, 2023, due to these assaults and his escalating behavior the decision was made on November 17, 2023, to not have him return to the facility. CNS-C said she attempted several times to contact the case manager, but they never responded, and after exhausting those efforts, the licensee finally concluded R4's discharge on November 28, 2023. CNS-C confirmed the OOLTC had not been notified as required. The licensee's undated Contract Termination/Emergency Relocation policy noted in the event of an emergency relocation, the facility must provide a written notice that contained, at a minimum: -the reason for the relocation -the name and contact information for the location to which the resident had been relocate and any new service provider	01070			

Minnesota Department of Health

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01070	Continued From page 33 -contact information for the Office of Ombudsman for Long-Term Care -if know and applicable, the approximate date or range of dates within which the resdient was expected to return to the facility, or a statement tat a return date was not currently known, and -a statement that, if the facility refused to provide housing or services after a relocation, the resdient had the right to appeal under section 144G.54. The facility would provide contact information for the agency to which the resident may submit an appeal. The notice required would be delivered as soon as practicable to: -the resident, legal representative, and designated representative -for resdient's who receive home and community-based waiver services under the resident's case manger, and -the Office of Ombudsman for Long-Term Care if the resident had been relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01070			
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living;	01560			

Minnesota Department of Health

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01560	Continued From page 34 (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, at 10:08 a.m., owner/agent (OA)-A stated all employees were trained on dementia care. OA-A stated he did not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form to consumers, and indicated he was not aware of	01560			

Minnesota Department of Health

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01560	Continued From page 35 this requirement. The licensee's Resident Records policy reviewed January 3, 2022, noted the resident record would contain other documents relevant to the resident's services or status. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620			

Minnesota Department of Health

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01620	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for two of two residents (R3, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: During the entrance conference on September 16, 2024, at 11:15 a.m., owner/agent (OA)-A stated the licensee was familiar with current minimum assisted living requirements. R3 R3's diagnoses included major depressive disorder, traumatic brain injury, car accident at age 12, hypertension (HTN/high blood pressure), diabetes, gastro-esophageal reflux disease (GERD/stomach acid,) and arthritis. On September 17, 2024, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-F go to R3's room and hand R3 two medication cups. ULP-F left the two medication cups with R3. ULP-F said, "I watch him (R3) when he is here, he is leaving." R3's record included a Master Assessment (90	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01620	Continued From page 37 day) dated August 20, 2024. R2 R2's diagnoses included diabetes, traumatic brain injury, HTN, and depressive episodes. On September 17, 2024, at 8:24 a.m., the surveyor observed ULP-F monitor R2's blood sugar to obtain a reading of 186. R2's record included a Master Assessment (90 day) dated July 15, 2024. Both R3 and R2's Master Assessments were lacking the following required content: -sleep schedule -spiritual and cultural preferences -risk for dehydration, history of urinary tract infection (UTI), current fluid intake -weight -smoking status. On September 18, 2024, at 11:09 a.m., the assessment tool used by the licensee was reviewed with clinical nurse supervisor (CNS)-C. On September 18, 2024, at 11:12 a.m., CNS-C stated the assessment tool used by the licensee did not include sleep schedule, spiritual and cultural preferences, risk for dehydration, history of UTI, current fluid intake, weight and smoking to include "the ability to smoke without causing burns or injury to the resident or others or damage to property. The licensee's Initial and On-Going Nursing Assessment of Residents policy reviewed January 3, 2023, noted a comprehensive assessment included but may not be limited to the requirements outlined by Minnesota rules.	01620			

Minnesota Department of Health

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01620	Continued From page 38 The comprehensive assessment would include sleep schedule, spiritual and cultural preferences, risk for dehydration, history of UTI, current fluid intake, weight and smoking to include "the ability to smoke without causing burns or injury to the resident or others or damage to property. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 39 (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for two of two residents (R3, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R3 R3's diagnoses included major depressive	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01640	Continued From page 40 disorder, traumatic brain injury, car accident at age 12, hypertension (HTN/high blood pressure,) diabetes, gastro-esophageal reflux disease (GERD/stomach acid,) and arthritis. R3's service plan dated March 17, 2024, indicated R3 received medication administration or assistance with self-administration, mental health management (with orientation, anxiety, depression) and housekeeping services. On September 17, 2024, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-F go to R3's room and hand R3 two medication cups. ULP-F left the two medication cups with R3. ULP-F said, "I watch him (R3) when he is here, he is leaving." R3's prescriber order dated May 30, 2024, included: -change to checking blood sugar once daily, call provider if blood sugar is less than 70 and pt (patient) symptomatic, staff can give juice if blood sugar is less than 70 then recheck in 30 minutes and monitor for symptom improvement. Call provider if blood sugar greater than 250. -monitor blood pressure once a week. Call provider if blood pressure is less than 90 systolic (top number) or if diastolic number is greater than 100. R3's service plan failed to include the services of blood sugar checks and blood pressure monitoring. On September 17, 2024, at 3:09 p.m., clinical nurse supervisor (CNS)-C stated R3's service plan did not include weekly blood pressure monitoring and daily blood sugar checks. CNS-C confirmed R3's service plan had not been revised	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01640	Continued From page 41 as required. R2 R2's diagnoses included diabetes, traumatic brain injury, HTN, and depressive episodes. R2's service plan dated April 13, 2023, indicated R2 received assistance dressing, grooming, bathing, continence care, assistance walking, medication administration or assistance with self-administration, orientation management, and housekeeping services. On September 17, 2024, at 8:24 a.m., the surveyor observed ULP-F hand R2 a small black case. R2 opened the case that contained a blood glucose meter, testing strips, wipes, lancet pen (used to make a small incision.) ULP-F removed the lancet pen and handed it to R2. ULP-F applied gloves, and ULP-F asked R2 if he was ready? ULP-F stated let me wipe your (R2's) hands. ULP-F chose R2's left pinky, cleaned the area, removed a blood testing strip out of a container and put the strip into the blood glucose testing monitor. R2 used the lancet and squeezed his pinky finger to obtain a drop of blood. ULP-F applied the droplet of blood onto the testing strip to obtain a reading of 186. R2's prescriber order dated August 2, 2024, included: -check blood pressure weekly, goal 140/90, call/notify MD (medical doctor) for blood pressure less than 90/60 or higher than 180/100. -check blood sugar once daily and as needed. If blood sugar is more than 500 pt (patient) to go to the ED (emergency department) for evaluation. If blood sugar is less than 80, drink four ounces juice -Ozempic (diabetes) injection four milligrams	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01640	Continued From page 42 (mg)/three milliliters (ml) inject one mg sub-q (subcutaneous/ into the fatty tissues under skin) every week. R2's service plan failed to include the services of blood sugar checks and blood pressure monitoring. On September 18, 2024, at 9:43 a.m., the surveyor observed R2 ambulating without assist. R2 stated ULPs do not assist him with daily showers, dressing, grooming. R2 said ULPs don't help him, and he does not want them to see "me" naked. On September 18, 2024, at 10:15 a.m., R2's service plan was reviewed with CNS-C. R2's service plan included the service of insulin injections, which was blank. CNS-C stated R2's service plan did not include injections weekly and should have. In addition, CNS-C stated currently R2 did not require assistance with grooming, bathing, dressing, walking as his sobriety was helping him (R2), adding, that was only because of a court order, he (R2) was not to drink. Owner/agent (OA)-A stated he was very open to changing the wording on the service plans to note reminders and cues, not services. CNS-C confirmed R2's service plan was not revised as required. The licensee's Contents of Service Plans policy dated January 3, 2022, noted all assisted living residents have an up-to date service plan identifying services to be proved based on the assessment by the RN (registered nurse) and/or other licensed health professional. Service plans and any revision to services plans would have a signature or other authentication by the facility and by the resident. Service plans were reviewed	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01640	Continued From page 43 and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure	01690			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318			
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01690	Continued From page 44 security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 16, 2024, at 11:11 a.m., clinical nurse supervisor (CNS)-C stated the facility provided medication management services to the licensee's residents. The licensee's provided policies lacked: - resolving medication errors. On September 18, 2024, at 1:16 p.m., via email, owner (O)-A indicated he had provided all of the medication policies the licensee used, and noted the licensee did not have this policy. No further information was provided.	01690			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01690	Continued From page 45	01690			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01700	Continued From page 46 individualized medication assessment with the 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) 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: During the entrance conference on September 16, 2024, at 11:27 a.m., licensed practical nurse (LPN)-G stated clinical nurse supervisor (CNS)-C completed service plans and stated medication management services were provided. R3's diagnoses included major depressive disorder, traumatic brain injury, car accident at age 12, hypertension (HTN/high blood pressure), diabetes, gastro-esophageal reflux disease (GERD/stomach acid), and arthritis. R3's service plan dated March 17, 2024, indicated R3 received medication administration or assistance with self-administration. On September 17, 2024, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-F go to R3's room and hand R3 two medication cups. ULP-F left the two medication cups with R3. ULP-F said, "I watch him (R3) when he is here, he is leaving." R3's Medication Assessment form dated March 17, 2024, included a review of 19 prescription medications:	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01700	Continued From page 47 -amlodipine 5 milligrams (mg) (HTN) -ascorbic acid 1000 mg (supplement) -aspirin 325 mg (heart health) -atorvastatin 80 mg (high cholesterol) -ezetimibe 10 mg (cholesterol) -levothyroxine 100 micrograms (mcg) (hyperthyroid) -Bupropion HCl 450 mg (depression) -lisinopril 40 mg (HTN) -multivitamin (supplement) -omega 3 (supplement) -pantoprazole 20 mg (GERD) -Stiolto 2.5-2.5 mg (shortness of breath/SOB) -vitamin D3 3000 units (supplement) -vitamin C 1000 mg (supplement) -rosuvastatin 20 mg (high cholesterol) -hydroxyzine 25 mg (anxiety) -Ventolin HFA inhaler (SOB) -acetaminophen 1000 mg (pain). Assessment included a risk of medication diversion, frequency, use, and common side effects. R3's prescriber order dated June 17, 2024, included all of the above medications. R3's record lacked evidence the RN had conducted a medication assessment to include: - contraindications - allergic or adverse reactions, and actions to address these issues. On September 18, 2024, at 11:09 a.m., R3's medication assessment was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated the assessment did not include allergies or contradictions of medications. CNS-C stated she had never included those items on the medication assessment.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01700	Continued From page 48 On September 18, 2024, at 1:48 p.m., CNS-C stated the medication assessment form would need to be changed to include allergies and medication contraindications. The licensee's Storage of Medications policy dated January 3, 2022, noted a register nurse must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident receiving	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 49 medication management services and documented those instructions for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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's diagnoses included diabetes, traumatic brain injury, hypertension (HTN/high blood pressure,) and depressive episodes. R2's service plan dated April 13, 2023, indicated R2 received medication administration or assistance with self-administration. On September 17, 2024, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-F hand R2 a small black case. R2 opened the case that contained a blood glucose meter, testing strips, wipes, lancet pen. ULP-F obtained a blood sugar reading of 186 for R2. ULP-F handed R2 a previously prepared medication cup of medications. R2 poured the medications onto the table. R2 took the prepared medication. R2's medication administration record (MAR) dated September 1, 2024, through September 17, 2024, included: -Ozempic (diabetes) four milligrams (mg)/milliliter (ml) injection one mg sub-Q (subcutaneous/ into the fatty tissues under skin) every week	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01750	Continued From page 50 -for: type 2 diabetes mellitus with diabetic neuropathy, unspecified -adverse effects: abdominal pain, constipation, diarrhea, fatigue, headache, nasopharyngitis, nausea, vomiting. R2's prescriber order dated August 2, 2024, included the above noted medication. The manufacturer's instructions for Ozempic dated October 2023, noted use a different injection site each week when injecting in the same body region. On September 18, 2024, at 9:58 a.m., R2 stated one of the "girls" (ULP/not a nurse) gave him a shot (injection) in his arm. R2 stated the site was cleaned and he could barely feel it (the injection.) R2 said sometimes he gets the "shot" in his stomach, and those bigger needles hurt sometimes. On September 18, 2024, at 11:05 a.m., clinical nurse supervisor (CNS)-C stated instructions for R2's Ozempic were added yesterday. CNS-C confirmed R2's MAR did not include specific instructions as required. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy reviewed January 3, 2022, noted the RN had developed written, specific instruction for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318			
(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
01760	Continued From page 51	01760			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees, (unlicensed personnel (ULP)-F). 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's diagnoses included diabetes, traumatic brain injury, hypertension (HTN/high blood pressure,)	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318		
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01760	Continued From page 52 and depressive episodes. R2's service plan dated April 13, 2023, indicated R2 received medication administration or assistance with self-administration. R2's medication administration record (MAR) dated September 1, 2024, through September 17, 2024, included: -amlodipine 5 milligrams (mg,) (HTN) 8:00 a.m. -duloxetine 60 mg, (depression) 8:00 a.m. -finasteride 5 mg, (prostate) 8:00 a.m., -folic acid 1 mg, (supplement 8:00 a.m. -gabapentin 300 mg, (diabetes nerve pain) 8:00 a.m. -glipizide 5 mg, (diabetes) 8:00 a.m. -jardiance 10 mg, (diabetes) 8:00 a.m. R2's prescriber order dated August 2, 2024, included the above noted medications. On September 17, 2024, at 8:24 a.m., the surveyor observed R2 seated at the dining room table. There was a plate of food sitting near R2. ULP-F went to get a cup of water from the kitchen. ULP-F handed R2 a small black case. R2 opened the case that contained a blood glucose meter, testing strips, wipes, lancet pen. ULP-F removed the pen type of lancet pen (device used for making a small incision) and handed it to R2. ULP-F asked R2 if he was ready? ULP-F stated, let me (ULP-F) wipe your (R2's) hands. ULP-F chose R2's left pinky finger, cleaned the area, removed a blood testing strip out of a container and put the strip into the blood glucose testing monitor. R2 used the lancet and squeezed his pinky finger to obtain a drop of blood. ULP-F applied the droplet of blood onto the testing strip to obtain a reading of 186. ULP-F removed the gloves and handed R2 a previously	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01760	Continued From page 53 prepared medication cup of medications. ULP-F placed the blood glucose meter and lancet pen back into the case. R2 poured the medications onto the table. ULP-F asked R2 to put the medication back into the cup. R2 took the medication. ULP-F picked up the prepared plate that was positioned near R2 and placed the plate of food in front of R2. ULP-F went to the kitchen to get a cup of coffee for R2. ULP-F placed the cup of coffee into the microwave. ULP-F asked R2 how he would like his coffee and added two scoops of sugar and milk into the coffee cup and then took the coffee to R2. ULP-F went to R5's doorway to announce breakfast was ready. The surveyor did not observe ULP-document R2's medication as administered. On September 17, 2024, at 8:32 a.m., ULP-F went to the medication room and documented R2's 8:00 a.m., medication as administrated. ULP-F stated she could not have documented R2's medication as administered before R2 took the medication. ULP-F stated she charted (documented) after R2 took the medication and she (ULP-F) got R5 (diagnosis dementia) to the table. On September 17, 2024, at 9:46 a.m., clinical nurse supervisor (CNS)-C stated ULPs should document at that time a medication was given, that (documentation) should be the focus of the ULP and the ULP should not do anything else before documenting. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy reviewed January 3, 2022, noted staff would document each task immediately after that task had been performed.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01760	Continued From page 54 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	01780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01780	Continued From page 55 portion or all of the residents). The findings include: During the entrance conference on September 16, 2024, at 11:11 a.m., clinical nurse supervisor (CNS)-C stated the facility provided medication management services to the licensee's residents. The licensee's Delegation of Medications To Be Given To Residents By Unlicensed Staff for Residents Time Away From Home policy, reviewed January 3, 2024, lacked the following required content: - for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse (RN); and - for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days. On September 18, 2024, at 1:16 p.m., via email, owner (O)-A indicated he had provided all of the medication policies the licensee used. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01790	Continued From page 56 medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident,	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318			
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01790	Continued From page 57 and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 16, 2024, at 11:11 a.m., clinical nurse supervisor	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01790	Continued From page 58 (CNS)-C stated the facility provided medication management services to the licensee's residents. The licensee's Delegation of Medications To Be Given To Residents By Unlicensed Staff for Residents Time Away From Home policy, reviewed January 3, 2024, noted the written procedures for the ULP providing medications for residents having unplanned time away when the licensed nurse was not available. The policy lacked the following required content: - a review by the RN of the completion of the task to verify it was completed accurately by the ULP. On September 18, 2024, at 1:16 p.m., via email, owner (O)-A indicated he had provided all of the medication policies the licensee used. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the medication was stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures for one of one resident (R2). In addition, the	01880			

Minnesota Department of Health

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01880	Continued From page 59 licensee failed to ensure medications were secure and permitted access to only authorized personnel in two of two medication carts (health facility identification/HFID 20957, HFID 20396) located in the medication room of HFID 20396. 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 finding include: MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS On September 16, 2024, at approximately 12:15 p.m., the surveyor reviewed the contents of the locked medication refrigerator located in a conference room in one of the buildings occupied by the licensee with licensed practical nurse (LPN)-G. LPN-G stated the current temperature was 29 degrees Fahrenheit (F). LPN-G stated she was not sure what the temperature of the refrigerator should be. LPN-G stated the house manager was in charge of checking the temperature of the refrigerator adding the licensee did not currently have a house manager, "left last week." LPN-G observed and confirmed the following content: -one unopened box of Ozempic (diabetes) four milligrams (mg) for R2. On September 16, 2024, at approximately 12:45 p.m., the surveyor was provided with a temperature log: - house name: office, date September 2024	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01880	Continued From page 60 The first and only entry on the page was September 16, 2024, at 12:30 p.m., 39 degrees F. On September 16, 2024, at 1:22 p.m., licensed assisted living director in residency (LALDR)-B stated she just found out the temperature of the medication refrigerator was not monitored in August as required. LALDR-B said the staff left (house manager) "walked out." LALDR-B stated she had just looked at the refrigerator's temperature and it was 33 degrees F. The surveyor inquired about the temperature of the medication refrigerator, as it was documented at 39 degrees F at 12:30 p.m., and the temperature was 29 degrees when LPN-G monitored it at approximately 12:15 p.m. LALDR-B replied, "I think we need a new thermometer." The manufacturer's instructions for Ozempic dated October 2023, noted Ozempic should stay refrigerated until the first time you use it. You should keep it in the refrigerator (between 36 F to 46 F) when it's new and unused. SECURE MEDICATION STORAGE On September 17, 2024, at 7:16 a.m., the surveyor observed unlicensed personnel (ULP)-F assisting an unidentified resident. The surveyor observed ULP-F leave the medication room with the medication room door open and ULP-F walked down the hallway. The surveyor walked into the medication room and observed both medication carts (two) unlocked. On September 17, 2024, at 7:18 a.m., ULP-F returned to the unlocked medication room. The surveyor asked ULP-F about the medication room door being left open, with both medication carts unattended and unlocked. ULP-F stated	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318			
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01880	Continued From page 61 "ok, the door was opened, but you (surveyor) were in here (medication room)." ULP-F stated she never leaves the medication door unlocked with both carts unlocked. On September 17, 2024, at 9:55 a.m., clinical nurse supervisor (CNS)-C stated leaving the medication room door unlocked was a "huge no." CNS-C said whoever was giving medication needed to remain in the medication room or the medication room door needed to be locked. CNS-C added they (facility) was fortunate as they have locked medication carts and a door but added they (door/carts) need to be locked when not in use. CNS-C said the person with the medication key was responsible and she (CNS-C) did not care who it was, no one should be left in the medication room with the medication carts unlocked but the person who had the key. The licensee's Storage of Medications policy dated January 3, 2022, noted medications would be handled and stored per acceptable standards. The register nurse (RN) would provide education including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. When secured storage of the medication was necessary the RN would identify where the medications would be stored, how they would be secured or locked under proper temperature controls and who had access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318		
(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
02320	Continued From page 62	02320			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. 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 by one of two unlicensed personnel (ULP)-F during medication for unplanned time away for 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 September 17, 2024, at 7:20 a.m., the surveyor observed ULP-I inform ULP-F that R3 would be going out for the day, and R3 required medications prepared, adding the nurse would be contacted. ULP-I said there were paper MARs (medication administration record) there (medication room).	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318		
(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
02320	Continued From page 63 On September 17, 2024, at 7:22 a.m., the surveyor observed ULP-F go to R3's room and hand R3 two white, unlabeled, paper medication cups. ULP-F left the two medication cups with R3. ULP-F said, "I watch him (R3) when he is here, he is leaving." On September 17, 2024, at 7:38 a.m., R3 stated the normal process was to give him a little cup and he (R3) put the cup in a purse type of bag. R3 stated he would be leaving at 9:00 a.m. R3's paper MAR dated August 28, 2024, to September 24, 2024, included the letter X written on the following medications, on September 17, 2024: -Bupropion HCL (major depressive disorder) 300 milligrams (mg), 10:00 a.m. -Bupropion HCL 150 mg, 10:00 a.m. -aspirin (heart health) 325 mg, 10:00 a.m. -Thera-tabs M tab (supplement), 10:00 a.m. -omega III, EPA + DHA (supplement), 10:00 a.m. -lisinopril (high blood pressure/HTN) 40 mg, 10:00 a.m. -ezetimibe (hyperlipidemia)10 mg, 10:00 a.m. -rosuvastatin (hyperlipidemia) 20 mg, 8:00 p.m. -atorvastantin (hyperlipidemia) 80 mg, 8:00 p.m. -vitamin D3 (supplement) 50 micrograms (mcg),10:00 a.m. -vitamin C (supplement) 1000 mg, 10:00 a.m. -pantoprazole (GERD) 20 mg, 8:00 a.m. (self/kept in room) -levothyroxin (hyperthyroidism) 150 mcg, 8:00 a.m. (self/kept in room) -vitamin C 1000 mg, 8:00 p.m. -hydroxyzpam (anxiety) 25 mg, PRN (as desired or as needed) -acetaminophen extra strength 500 mg, two tablets for pain, PRN -Stiolto AER (open airways) 2.5-2.5 inhaler 8:00	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318		
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02320	Continued From page 64 a.m., (self). R3's prescriber order dated June 17, 2024, included all of the above noted medications. R3's paper MAR was authenticated with licensed practical nurse (LPN-G) first name and initials. LPN-G did not document her title or last name. R3's paper MAR was not signed by ULP-F nor were ULP-F's initials on R3's paper MAR. On September 17, 2024, at 9:42 a.m., clinical nurse supervisor (CNS)-C stated LPN-G trained staff to use little envelopes to package medications that would be administered when out of the facility. CNS-C added if a resident was going to be gone for an extended period of time a medication "bar" (medication dosage box system) would be used. CNS-C said, ULPs were to write the time, date, name of medication, how many pills were in there, and include a medication list, so the person (resident) knew the medication they were taking at that time. CNS-C said medication cups can spill and documentation should have been done on paper MARs at the time. CNS-C confirmed unplanned medications were not prepared per CNS-C's expectation. On September 17, 2024, at approximately 1:45 p.m., licensed assisted living director (LALD)-B reviewed ULP-F's training record for unplanned time away medications. ULP-F completed the training June 15, 2023, and on March 7, 2024. On September 17, 2024, at 2:01 p.m., LPN-G stated a ULP called her, and she (LPN-G) instructed the ULP to use the paper MAR that morning. R3's MAR dated August 28, 2024, to September 24, 2024, was reviewed with LPN-G. LPN-G said "they" (ULP) X' ed the medications,	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318			
(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
02320	Continued From page 65 did not sign on the bottom of the form, and no initials were documented. LPN-G confirmed the documentation on R3's MAR was not completed correctly and R3's medications were not sent out correctly. The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Resident Time Away from Home policy dated January 3, 2022, noted: -staff would contact the registered nurse (RN) on-call upon notification by resident or family of plans to be absent during medication administration times to seek directions -review the MAR to determine the medications that would need to be sent with the resident -obtain medication that would be needed for planned LOA (leave of absence) -obtain the agency "package of forms" needed to accompany the medications. (Examples may include cover letter from RN with contact information, a current copy of the medications to be taken during the LOA in a manner the resident or resident's representative can understand. RN/LPN or ULP would obtain an envelope for each scheduled medication time. The envelope would be completed with the resident's name, date, medication included and time to take medication -document the medications given in format required by agency by medication, does, quantity and name of individual to whom the mediation was given -request signature from resident and/or resident's representative signature to attest receipt of information on medication release form. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy reviewed January 3, 2022, noted staff	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER EMPOWERMENT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 112005 HIDDEN CREEK PLACE CHASKA, MN 55318			
(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
02320	Continued From page 66 would document each task immediately after that task had been performed. Documentation would follow [professional standards for documentation, including the requirement that entries must be: -legible -dated with the time of entry -authenticated with the name and title of the person making the entry. When initials are used by persons making entries in the resident record, the person will authenticate initials with a full signature and title. The signature and title may be included on the same document -staff would use only approved health care abbreviation identified by the RN and agency. The licensee's Resident Records policy reviewed January 3, 2022, noted record entries would be legible, permanently recorded, dated, and signed by the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			

Type: Full
Date: 09/16/24
Time: 12:31:48
Report: 7994241163

Food and Beverage Establishment Inspection Report

Page 1

Location:

Empowerment Healthcare
112005 Hidden Creek Place
Chaska, MN55318
Carver County, 10

Establishment Info:

ID #: 0039312
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635660831
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.110 **** Priority 2 ****

MN Rule 4626.0785 Provide the proper wash water temperature for the warewashing machine as specified in rule and the manufacturer's data plate.

CURRENTLY FACILITY IS NOT KEEPING RECORDS OF THE DISHWASHER TESTING. FACILITY WILL TEST DISHWASHER AND EMAIL PICTURES TO INSPECTOR.

Comply By: 09/16/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ONE CFPM IS REQUIRED FOR EVERY 2 FACILITIES. CURRENTLY THERE IS JUST ONE FOR ALL 4 HOUSES AT THE MOMENT.

Comply By: 09/16/24

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

LIGHT BULBS OVER KITCHEN AREA FOUND UNSHIELDED.

Comply By: 09/16/24

Type: Full
Date: 09/16/24
Time: 12:31:48
Report: 7994241163
Empowerment Healthcare

Food and Beverage Establishment Inspection Report

Page 2

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

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

FLOOR IS LAMINANT, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

THIS FACILITY IS ATTACHED VIA DOOR TO THE 112007 BUILDING (ROSEWOOD)

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 7994241163 of 09/16/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Signed: _____

Establishment Representative

Signed:  _____

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us