Electronically Delivered

September 19, 2022

Administrator
The Encore at Hugo
5607 150th Street North
Hugo, MN 55038

RE: Project Number(s) SL30353015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 24, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT HUGO	5607 150TH STREET NORTH HUGO, MN 55038

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30353015 On August 22, through August 24, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 21 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 21 current 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, 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: Please refer to the additional documentation included in the Food and Beverage Establishment	0 480		

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0 480	Continued From page 2 Inspection Reports, dated August 22, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to publicly post a	0 680		

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0 680	Continued From page 3 written emergency preparedness plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 22, 2022, at approximately 10:00 a.m., during a tour of the facility, the surveyors did not observe an emergency disaster plan posted prominently. The surveyors requested to review the licensee's emergency disaster plan. Registered nurse (RN)-A retrieved a 3-ringed binder from a locked medication room and identified the binder as licensee's emergency disaster plan. The emergency disaster plan lacked the following required content: - succession planning with delegation of authority - communication plan and employee tree of authority - names/contact information of residents' providers, pharmacy, or entities who provided services to residents On August 24, 2022, at approximately 11:00 a.m., RN-A and administrator (A)-D acknowledged the licensee's emergency disaster plan was not posted prominently and lacked the required	0 680		

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0 680	Continued From page 4 content. The licensee's undated 10.03MN Disaster Planning and Emergency Preparedness policy indicated the emergency disaster plan would include all required content. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain monthly visual inspections on portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 5 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 23, 2022, approximately from 10:30 a.m. to 12:05 p.m. survey staff toured the facility with the administrator (A)-D, and from approximately 11:15 a.m. to 12:05 p.m. the maintenance staff (M)-E joined the tour. During the tour, survey staff observed the following findings: 1) The portable fire extinguishers installed throughout the facility were serviced with an annual service date of March 2021 but lacked records to show the required monthly visual inspections. 2) The portable fire extinguisher secured inside the steel case located near the dining area next to the door to the courtyard was not accessible. Survey staff asked the A-D to open the case and the administrator attempted but could not find the correct key and was unsure if all staff had the key to access the secured extinguisher. Survey staff explained that all portable fire extinguishers must be readily accessible. On August 23, 2022, at approximately 12:50 p.m., the A-D acknowledged the above findings. Survey staff explained to the A-D, that if provision was made to secure the portable fire extinguishers to protect the dementia care residents from access due to safety risks, the requirement of ready	0 790		

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0 790	Continued From page 6 access and proper staff training must be implemented and be in-placed for the use of the portable fire extinguishers as necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On August 23, 2022, approximately from 10:30	0 800		

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0 800	Continued From page 7 a.m. to 12:05 p.m. survey staff toured the facility with the administrator (A)-D, and from approximately 11:15 a.m. to 12:05 p.m. the maintenance staff (M)-E joined the tour. During the tour, survey staff, the A-D, and the M-E observed the following: 1) No carbon monoxide alarms and/or detection systems were provided at required locations of sleeping rooms or in mechanical rooms for compliance carbon monoxide detection in buildings with fuel-burning equipment/appliance in accordance with state law. 2) Fire sprinkler escutcheons were missing at various locations throughout the building. Survey staff observed missing escutcheons in the meeting room where MDH employees occupied during the survey, in the mechanical rooms, in the corridor near the A-D office, and resident bedroom 19. Survey staff explained that all fire sprinklers must be verified to ensure all escutcheons are provided for proper operation of the fire sprinkler heads during activation of the system. 3) The fire sprinkler head including the glass tube, the frame, and the deflector plate located in the laundry room was layered with thick dust. 4) The exhaust vents (duct) in the ceiling of the laundry room had openings around the vents and lacked fire sealant to maintain the fire rating of the room. On August 23, 2022, at approximately 12:50 p.m., the A-D and the M-E acknowledged the above findings. Survey staff stated that new information on the carbon monoxide alarms may be submitted and honored if survey staff received	0 800		

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0 800	Continued From page 8 the information by the end of the next day to substantiate the above finding on the carbon monoxide alarms. The facility will need to review with a professional with expertise in this area or with their administrative authority for compliance with the requirement. Survey staff advised the A-D that more information and factsheets on carbon monoxide requirements can be found at the state fire marshal webpage. Additional information was received from the A-D via email on August 24, 2022, at 7:06 p.m. stating that the facility has ordered combination of carbon monoxide and smoke units for each of the twenty-four resident bedrooms. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 9 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the correct frequency of employee fire safety and evacuation drills, and the minimum required staff training on fire safety and evacuation. This has the potential to directly affect the safety of staff and all residents receiving care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 23, 2022, at approximately 12:20 p.m., survey staff requested and received the facility fire safety and evacuation plan and related	0 810		

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0 810	Continued From page 10 documentation for review from the administrator (A)-D. Document review indicated the following findings: 1) Documentation review showed the licensee lacked a record of employee training specifically on the fire safety and evacuation plan for the facility. The minimum required employee training is upon hire and twice a year for fire safety and evacuation. Survey staff explained that the fire safety and evacuation training was in addition to the annual required emergency preparedness plan training . 2)The drill records showed an insufficient number of employee fire safety and evacuation drills performed to date. Drill records received for review were dated June 2, 2022, at 1:12 p.m. and on the same day at 3:50 p.m. On August 23, 2022, at approximately 12:50 p.m., the A-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01540		

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01540	Continued From page 11 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct-care staff completed at least two hours annual training for one of one unlicensed personnel ((ULP)-B), with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B started employment on May 22, 2020. ULP-B's record lacked documentation the employee had completed the required two hours annual training related to dementia care. On August 23, 2022, at approximately 8:25 a.m., (ULP)- B assisted R1 with a wheelchair to bed transfer and positioned R1 in bed.	01540		

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01540	Continued From page 12 On August 24, 2022, at approximately 11:00 a.m., registered nurse (RN)-A acknowledged ULP-B's record lacked evidence of the required annual training in dementia care. RN-A stated ULP-B had completed required initial dementia care training but was overdue for annual dementia care training. The licensee's 5.49 Dementia Training policy dated July 2021, indicated all staff would complete two (2) hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650		

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	30353	A. BUILDING: _____ B. WING _____	08/24/2022

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01650	Continued From page 13 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents' service plans included all required content for three of three residents (R1, R2, R3) with records reviewed. 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: R1's Service Plan Detail was dated July 12, 2022. R2's Service Plan Detail was dated July 11, 2022. R3's Service Plan Detail was dated July 1, 2022. R1, R2, and R3's Service Plan Details lacked the schedule and methods of monitoring assessments of the resident and of monitoring staff who provided services.	01650		

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01650	Continued From page 14 On August 24, 2022, at approximately 11:00 a.m., administrator (A)-D and registered nurse (RN)-A acknowledged the licensee's service plans as identified lacked the required content. RN-A indicated the licensee's electronic health program provided the tracking for the required items but were not included on the service plan. The licensee's 2.08MN Service Plan policy dated July 2021, indicated all required content for residents' service plans would be included. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	01730		

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01730	Continued From page 15 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management record with the required content for two of three residents (R1, R3), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01730		

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01730	Continued From page 16 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on August 17, 2020. R1's medication administration record (MAR) dated August 2022, included documentation of medication administration from unlicensed personnel (ULP) throughout the month of August. R1's Medication/Treatment/Therapy Management Plan dated July 14, 2022, indicated R1 to received medication administration. R1's service plan dated July 14, 2022, lacked documentation that R1 received medication management. R3 R3 was admitted on February 18, 2022. R3's August 2022, MAR (medication administration record), included documentation of medication administration from (ULP) throughout the month of August. R3's Medication/Treatment/Therapy Management Plan dated July 1, 2022, indicated R3 received medication administration. R3's service plan dated July 1, 2022, lacked documentation that R3 received medication management. On August 22, 2022, at approximately 10:00 a.m.,	01730		

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01730	Continued From page 17 registered nurse (RN)-A acknowledged all residents received medication management services. The licensee's 2.35MN Medication & Treatment-Administration and Delegation policy dated July 2021, indicated medication services would be included on the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

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01940	Continued From page 18 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of two residents (R1), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on August 17, 2020. R1's physician order dated July 11, 2022, indicated R1 received oxygen at two liters per minute for oxygen level less than 90%. The order also indicated to check oxygen saturation every shift and as needed with shortness of breath/wheezing. R1's service plan dated July 14, 2022, lacked documentation the resident received the	01940		

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01940	Continued From page 19 treatment service of oxygen therapy. On August 23, 2022, at approximately 8:25 a.m., unlicensed personnel (ULP)-B administered a nebulizer treatment to R1. The surveyor observed oxygen tanks and tubing in R1's room. On August 24, 2022, at 11:00 a.m., registered nurse (RN)-A acknowledged R1's most current signed service plan did not include oxygen therapy as a service to be provided. The licensee's Medication/Treatment/Therapy Management Plan dated July 14, 2022, indicated R1 to receive oxygen therapy. The licensee's 2.35MN Medication & Treatment-Administration & Delegation policy dated July 2021, indicated treatment therapy would be included on the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided	01960		

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01960	Continued From page 20 to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for one of two residents (R1), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on August 17, 2020. R1's physician order dated July 11, 2022, read, "R1 to receive oxygen at two liters per minute for oxygen level less than 90%. Check oxygen saturation every shift and as needed with shortness of breath/wheezing." R1's service plan updated July 14, 2022, indicated R1 received services to include assistance with medication management, and monitoring of vital signs (including oxygen saturation), but lacked identification of oxygen. R1's medication administration record (MAR) dated August 2022, indicated two liters of oxygen should be applied to R1 if oxygen level was below 90%. -August 1, 2022, at 10:00 p.m., oxygen level	01960		

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01960	Continued From page 21 was recorded at 89%, but no documentation oxygen was applied. -August 3, 2022, at 8:00 a.m., oxygen level was recorded at 89%, but no documentation oxygen was applied. On August 23, 2022, at approximately 8:25 a.m., unlicensed personnel (ULP)-B assisted R1 with a nebulizer treatment. ULP-B stated R1's oxygen saturation is checked once per shift and if oxygen saturation is below 90%, staff will apply two liters of oxygen to R1. On August 24, 2022, at approximately 11:00 a.m., registered nurse (RN)-A acknowledged the MAR lacked documentation of oxygen administration but stated staff would have applied oxygen. The licensee's 2.35MN Medication & Treatment-Administration & Delegation policy dated July 2021, indicated ULPs would document all provided treatments and/or therapies administered. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the	02040		

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02040	Continued From page 22 assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On August 23, 2022, from approximately 10:30 a.m. to 12:05 p.m., survey staff toured the facility with the administrator (A)-D, and from approximately 11:15 a.m. to 12:05 p.m. the maintenance staff (M)-E joined the tour. On August 23, 2022, at approximately 12:20 pm, a documentation review and interview were performed with the A-D on the hazard vulnerability or safety risk assessment for the memory care physical environment.	02040		

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02040	Continued From page 23 1) Review of the plan documentation indicated the licensee had not performed a site-specific safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. This finding was evident as the documentation provided did not include site-specific vulnerability content on safety risk assessment on and around the property. 2) Review of the plan documentation indicated the licensee did not identify mitigations to protect memory care residents from harm. Prevention measures to mitigate risks from identified potential hazards and vulnerabilities must be developed and documented in the plan. On August 23, 2022, at approximately 12:50 p.m., the A-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and	02110		

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02110	Continued From page 24 design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to three of three residents (R1, R2, R3) with records reviewed. 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	02110		

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02110	Continued From page 25 or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3's records lacked evidence the resident or residents' representative were provided the additional required policies and procedures for assisted living facilities with dementia care. On August 24, 2022, at approximately 11:00 a.m., administrator (A)-D and registered nurse (RN)-A acknowledged the residents' records lacked evidence the policies and procedures were provided. RN-A stated the licensee had created the policies and procedures but were not aware they were required to be provided to the residents or residents' representatives. RN-A indicated the policies and procedures were not provided to any residents or residents' representatives. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to	02170		

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02170	Continued From page 26 participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activity plan contained all required content for three of three residents (R1, R2, R3) with records reviewed. 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	02170		

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THE ENCORE AT HUGO	5607 150TH STREET NORTH HUGO, MN 55038

(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
02170	Continued From page 27 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: R1, R2, and R3's 3.01F Activities Assessment Form dated May 20, 2021, August 3, 2022, and May 9, 2022, respectively, lacked assessment of the residents' past interests, current abilities and skills, emotional and social needs and patterns, physical limitations, and identifications of activities for behavioral interventions. On August 24, 2022, at approximately 11:00 a.m., administrator (A)-D and registered nurse (RN)-A acknowledged R1, R2, and R3's activities assessment lacked required content. RN-A stated the form was used for all residents and would need to be updated to capture all areas required to be assessed for each resident. The licensee's 3.01 Activities Assessment policy dated December 2020, indicated an activities assessment would be completed for each resident, but lacked identification of the required content for the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02350 SS=F	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect.	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT HUGO	5607 150TH STREET NORTH HUGO, MN 55038

(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
02350	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language for termination of an assisted living contract without reason or cause for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 22, 2022, at approximately 10:00 a.m., administrator (A)-D provided the licensee's Residency Agreement, and indicated the document is used for all residents who received services and as licensee's assisted living contract. On page seven (7) of fifteen (15) under VII. Termination of Agreement, section B, the contract read, "We may terminate this agreement at any time upon thirty (30) day written notice to you, with or without cause." Additionally, at the end of the section the contract read, "The community will provide limited assistance to you in finding alternative accommodations if either party terminates this agreement, including referring you to the Senior Linkage Line for assistance. The community cannot guarantee that s/suitable alternative accommodations can be found for you."	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02350	Continued From page 29 Minnesota statute 144G.52 subdivision 2 and subdivision. 7 dated August 1, 2021, indicated the licensee is required to have cause for termination and to provide written notice to the Office of Ombudsman for Long-Term Care. Minnesota statute 144G.55 subdivsion 1 dated August 1, 2021, indicated the licensee must help coordinate the transition to a safe location that is appropriate for the resident. On August 24, 2022, at approximately 11:00 a.m., A-D acknowledged the licensee's contract included language not consistent with statutory requirements. The licensee's 1.25MN Resident Contract Termination policy dated July 2021, included all required content for the termination of an assisted living contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02350		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64975
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *08/22/22*
Time: 13:08:02
Report: 8058221141

Food and Beverage Establishment Inspection Report

Location:
The Encore At Hugo
5607 150th Street North
Hugo, MN55038
Washington County, 82

Establishment Info:
ID #: 0039287
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516533282
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

ITEMS IN WALK IN COOLER ABOVE 41DF - SEE COMMENTS

Comply By: 08/22/22

7-100 Toxic Labeling

7-102.11 ** Priority 2 **

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SANITIZER BOTTLE IDENTIFIED BY LABEL AS Q. AMMONIA INSTEAD CONTAINED A PEROXIDE SOLUTION. NO TEST STRIPS AVAILABLE - SEE COMMENTS - CORRECTED ON SITE

Comply By: 08/22/22

Surface and Equipment Sanitizers

Hot Water: --- at 185 Degrees Fahrenheit
Location: DISH MACHINE - MANIFOLD
Violation Issued: No

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit
Location: SINK DISPENSER
Violation Issued: No

PEROXIDE: = na at --- Degrees Fahrenheit
Location: SPRAY BOTTLE - MISSLABLED
Violation Issued: Yes

Type: Full
Date: *08/22/22*
Time: 13:08:02
Report: 8058221141
The Encore At Hugo

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: TOMATO
Temperature: 43 Degrees Fahrenheit - Location: WALK IN
Violation Issued: Yes

Process/Item: CHICKEN
Temperature: 43 Degrees Fahrenheit - Location: WALK IN
Violation Issued: Yes

Process/Item: TUNA
Temperature: 42 Degrees Fahrenheit - Location: WALK IN
Violation Issued: Yes

Process/Item: YOGURT
Temperature: 43 Degrees Fahrenheit - Location: WALK IN
Violation Issued: Yes

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

DEDICATED MEMORY CARE UNIT - COMMERCIAL KITCHEN

HRD INSPECTOR ANNA BOHNEN
ESTABLISHMENT OPERATOR ALSO PRESENT (MANAGER ON DUTY)

NOTES:

TEST STRIPS ON SITE FOR QUAT. PRODUCT AT KITCHEN SINK DISPENSER, ADVISED THE USE OF THIS SANITIZER SOLUTION. EMPLOYEE DISCARDED MISSLABELED BOTTLES AND REPLACED THEM WITH A TESTED QUAT SOLUTION IN A CORRECTLY LABELED BOTTLE

WALK IN COOLER TEMPERATURE MAY BE AFFECTED BY HEAVY USE DURING LUNCH OR DUE TO THE NEED FOR A MECHANICAL ADJUSTMENT. ADVISED THAT TEMPERATURE BE MONITORED OF ACTUAL FOOD PRODUCTS (NOT AIR TEMP) AND ADJUST AS NEEDED

Type: Full
Date: *08/22/22*
Time: 13:08:02
Report: 8058221141
The Encore At Hugo

Food and Beverage Establishment Inspection Report

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 8058221141 of 08/22/22.

Certified Food Protection Manager: MINDY LACLAIR

Certification Number: 54475 Expires: 08/24/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us