Electronically Delivered

May 8, 2025

Licensee
The Encore at Champlin
11469 Jefferson Court North
Champlin, MN 55316

RE: Project Number(s) SL30609016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 2, 2025, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

§ 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: 651-201-5871
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30609	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT CHAMPLIN	11469 JEFFERSON COURT NORTH CHAMPLIN, MN 55316

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30609016-0 On March 31, 2025, through April 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 27 residents; 27 receiving services under the provider's Assisted Living with Dementia Care 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 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: 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 April 1, 2025, 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		

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0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure employee records included all required content for one of three 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	0 650		

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0 650	Continued From page 4 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 November 16, 2023, and provided direct cares and services for residents of the facility. ULP-F"s employee file included documentation of initial training completed November 17, 2023. The record lacked evidence of 8 hours of annual training completed for each 12 months of employment. On April 1, 2025, at approximately 11:15 a.m., clinical nurse supervisor (CNS)-C stated the annual training was completed; however, she was unable to locate the annual training in the employee file. The licensee's Required Annual Staff Training policy dated January 20, 2021, indicated, "All staff of [licensee], that performs direct home care services will complete a minimum of 8 hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 5 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included Tuberculin Skin Testing (TST) no greater than 90 days prior to hire date for one of three 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment dated November 11, 2024, indicated the facility was a low risk	0 660		

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0 660	Continued From page 6 setting for TB transmission. ULP-F was hired November 16, 2023, and provided direct cares for residents of the facility. ULP-F's employee record included documentation of two negative TST's dated March 7, 2025, and March 21, 2025. ULP-F's record lacked documentation of a baseline TB screening completed at the time of hire, or within 90 days prior to hire. On April 1, 2025, at approximately 12:00 p.m., clinical nurse supervisor (CNS)-C stated ULP-F's employee record lacked baseline TB screening at time of hire. CNS-C further stated when they realized ULP-F's employee file lacked TB screening, she had ULP-F complete the first step TST. The licensee's TB Screening policy dated February 2022, indicated licensee would maintain a comprehensive TB infection control program according to the most current TB infection control guidelines issued by the CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that	0 660		

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0 660	Continued From page 7 documentation could be substituted for documentation of a previous positive TST or blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 8 by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan 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 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 March 31, 2025, at 1:15 p.m., the EP plan was reviewed and found to lack documentation of annual review and the following requirements: - Policy and procedure with arrangement agreements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Must conduct exercises to test the EP plan at least twice per year, including unannounced staff drills using the EP plan; - Must participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR	0 680		

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0 680	Continued From page 9 table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On March 31, 2025, at 1:45 p.m., administrator (A)-A stated the licensee's EP plan lacked the information noted above. A-A further stated licensee had been working on the required content of the EP plan; however, the EP plan was not completed yet. The licensee's Disaster Planning and Emergency Preparedness policy dated July 2021, indicated, licensee would have in place a general emergency preparedness plan, that is in alignment with facilities requirement to also comply with Centers for Medicare and Medicaid Services (CMS) Appendix Z. No further information was provided. TIME FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code provisions. This deficient condition had the ability to affect all staff and residents.	0 775		

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0 775	Continued From page 10 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 April 2, 2025, at approximately 9:00 a.m. the surveyor toured the facility with administrator/ licensed assisted living director-in-residency (A)-A. During the tour, the surveyor observed the following: 1. The 5-year fire protection internal inspection service tag was dated 2017. The wet system service report from Summit Fire Protection dated 2-19-2025 noted the 5-year internal inspection was due. Maintinace of the fire protections systems shall be in compliance with MSFC Sec. 901.6. During the facility tour interview on April 2, 2025, A-A stated she would discuss this with the maintenance staff. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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	0 800		

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0 800	Continued From page 11 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, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 2, 2025, at approximately 9:00 a.m., the surveyor toured the facility with administrator/licensed assisted living director-in-residency (A)-A. The following was observed. GENERAL MAINTENANCE: The walls inside the memory care storage room adjoining the dining room area had a large amount of sheet rock and insulation removed	0 800		

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	30609	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT CHAMPLIN	11469 JEFFERSON COURT NORTH CHAMPLIN, MN 55316

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0 800	Continued From page 12 from the walls. In the assisting living nurses station electrical wires were not protected and exposed to the staff. The condensate pipe for the furnace in the memory care furnace room was broken and leaking liquid on the furnace and ductwork causing a large amount of corrosion to the HVAC equipment potentially jeopardizing indoor air quality. The exterior walkway outside the emergency exit in the memory care dining room was sunken and created a fall hazard potentially compromising the use of the emergency exit. On April 2, 2025, A-A stated they understood the above-listed deficiencies. 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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 13 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 14 On April 2, 2025, administrator/licensed assisted living director-in-residency (A)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On April 2, 2025, A-A stated they understood the area of their policy that was incomplete and would work on bringing the FSEP policy into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated staff were trained upon hire but failed to provide training to employees on the FSEP twice per year. No other training documentation was provided. On April 2, 2025, A-A stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements.	0 810		

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0 810	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01540 SS=F	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 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received eight hours of initial dementia care training within the first 80 working hours of employment, and two hours of dementia training annually for direct care employees as required for two of three employees (unlicensed personnel (ULP)-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01540		

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01540	Continued From page 16 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired September 9, 2024. ULP-E's employee record indicated 6.5 hours of dementia care training completed between December 4, 2024, and March 30, 2025. ULP-E's record lacked evidence of eight hours of initial dementia care training completed within the first 80 hours of working. ULP-F ULP-F was hired November 16, 2023. ULP-F's employee record lacked evidence of two hours of annual dementia training. On March 31, 2025, at 10:20 a.m., during the entrance conference, administrator (A)-A stated she was aware of the required content of the employee record. On April 1, 2025, at approximately 11:15 a.m., clinical nurse supervisor (CNS)-C stated employee files lacked the information noted above. CNS-C further stated employee dementia training was completed; however, she was unable to locate the dementia training in the employee file. The licensee's Dementia Training policy dated	01540		

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01540	Continued From page 17 September 2022, indicated all staff of licensee would be required to complete dementia training at the time of hire and annually thereafter. Furthermore, direct care employees would complete eight (8) hours of initial training within 80 hours of the employment start date, and employees would not provide direct care until the training was complete unless another employee who has completed the initial training was present to provide assistance. Moreover, 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		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident	01620		

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01620	Continued From page 18 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) completed reassessment and monitoring no more than 14 calendar days after initiation of services. Further, the licensee failed to ensure the RN conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the previous reassessment, for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5 was admitted to licensee for cares and services on October 7, 2024. R5 had diagnoses to include, but not limited to Alzheimer's disease, closed fracture of clavicle, osteoarthritis of multiple joints, major depressive disorder, recurrent, unspecified, and essential (primary) hypertension. R5's service plan dated October 7, 2024,	01620		

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01620	Continued From page 19 indicated R5 received services including housekeeping, laundry, reminders for dressing, grooming, bathing, and medication administration. R5's record included documentation of a pre-admission nursing assessment completed on October 4, 2024, and a 14-day reassessment completed on October 23, 2024, which was more than 14 days after initiation of services. R5's record included a 90-day RN nursing reassessment completed on January 26, 2025, which was more than 90 days after the previous assessment. On April 1, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-C stated due to licensee switching to a new electronic record system and the volume of paperwork it created, she was unable to keep up with the workload. Furthermore, CNS-C stated licensee was admitting new residents during that same time, which caused her to fall behind on assessments. The licensee's Assessments, Reviews, and Monitoring policy dated July 2021, indicated an initial nursing assessment or reassessment would include all the elements of the uniform assessment tool as required, be in writing, dated, and signed by the registered nurse who conducted the assessment. Moreover, resident reassessment and monitoring would be conducted no more than 14 calendar days after initiation of services, and ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and would not exceed 90 calendar days from the last date of the assessment	01620		

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01620	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Type: Full
Date: *04/01/25*
Time: 13:30:00
Report: 1043251093

Food and Beverage Establishment Inspection Report

Location:
The Encore At Champlin
11469 Jefferson Court North
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0038486
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632353600
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

4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

FACILITY USES QUATERNARY AMMONIA. DISPENSER AT 3 COMP SINK MEASURED 0 PPM. ADVISED STAFF TO MANUALLY MIX SANITIZER TO MEASURE BETWEEN 200-400 PPM UNTIL DISPENSER IS SERVICED. COMPLY WITH ABOVE RULE.

Comply By: 04/01/25

2-100 Supervision

2-101.11 ***** Priority 2 *****

MN Rule 4626.0025 Designate a person in charge and ensure that the person in charge is present in the establishment during all hours of operation.

REPEAT FROM 1/5/23. NO MDH CFPM EMPLOYED. ADVISED STAFF TO EMPLOY A FULL TIME EMPLOYEE AS A CFPM. INFO PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 04/01/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

FACILITY USES QUATERNARY AMMONIA. SANI BUCKET MEASURED 0 PPM. ADVISED STAFF TO MAINTAIN CONCENTRATION BETWEEN 200-400 PPM. COMPLY WITH ABOVE RULE.

Comply By: 04/01/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

1. REPEAT FROM 1/5/23. WALK IN FREEZER HAS SIGNIFICANT BUILD UP OF ICE AROUND CONDENSER UNIT. 2. SANITIZER DISPENSER MEASURED AT 0 PPM. ADVISED STAFF TO REPAIR UNITS TO BE IN GOOD REPAIR. COMPLY WITH ABOVE RULE.

Comply By: 04/01/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 0 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: Yes

Quaternary Ammonia: = 0 PPM at Degrees Fahrenheit
Location: SANI DISPENSER
Violation Issued: Yes

Hot Water: = at 162 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: LIQUID EGG
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: BEEF
Temperature: 32 Degrees Fahrenheit - Location: THAWING
Violation Issued: No

Type: Full
Date: *04/01/25*
Time: 13:30:00
Report: 1043251093
The Encore At Champlin

Food and Beverage Establishment Inspection Report

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

Inspection was completed with Rhonda Makela as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, illness policy, sanitizer use, ware washing, temperature control, cleaning, test kits, food storage, and food handling procedures.

Facility has a commercial kitchen that is shared between Assisted Living and Memory Care.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 1043251093 of 04/01/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Kathy Herbert
Kitchen PIC

Signed:_____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us