DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 19, 2023

Licensee
The Encore at North Branch
38610 14th Avenue
North Branch, MN 55056

RE: Project Number(s) SL30608015

Dear Licensee:

On February 16, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 23, 2022, survey were corrected. This follow-up survey verified that the facility is back in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker's, Supervisor
State Evaluation Team
Email: Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

Electronically Delivered

January 10, 2023

Licensee
The Encore at North Branch
38610 14th Avenue
North Branch, MN 55056

RE: Project Number(s) SL30608015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 23, 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.

LICENSING ORDERS
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, the following fines are assessed pursuant to this evaluation:

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

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: 651-201-3789 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30608	A. BUILDING: _____ B. WING _____	12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT NORTH BRANCH	38610 14TH AVENUE NORTH BRANCH, MN 55056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 30608015 On December 19, through December 21, 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 30 residents receiving services under the Assisted Living with Dementia Care license. On December 20, 2022, immediate orders were issued for 2070 and 2310. The immediacy was removed on and December 21, 2022.	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 30 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 December 19, 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 interview and record review, the licensee failed to have a written emergency	0 680		

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0 680	Continued From page 3 preparedness 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) 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 December 19, 2022, at 2:15 p.m., administrator (A)-D stated the licensee had not developed a written emergency preparedness plan with all the required content. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

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0 730	Continued From page 4 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included documentation of services provided as	0 730		

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0 730	Continued From page 5 identified in the service plan for three of five residents (R3, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3's diagnoses included bipolar disorder, anxiety disorder, and depression. R3's service plan dated November 22, 2022, indicated R3 received assistance with showers, housekeeping, laundry, and safety checks. R3's record lacked documentation of services provided for all services at various times of the day on the following days: December 1, 4, 6, 8, 11, 13-15, 17, and 18, 2022. R5 R5's diagnosis included cerebral infarction (stroke), history of falls, dizziness, and depression. R5's service plan dated October 18, 2022, indicated R5 received assistance with toileting, bathing, dressing, grooming, and mobility. R5's record lacked documentation of services provided for all services at various times of the day on the following days: December 1, 4, 6, 8, 11, 13-15, 17 and 20, 2022.	0 730		

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0 730	Continued From page 6 R6 R6's diagnoses included chronic obstructive pulmonary disease (difficulty breathing), fibromyalgia, kidney disease and heart disease. R6's service plan dated September 22, 2022, indicated R6 received assistance with dressing, grooming, bathing, toileting, transfers, mobility, and repositioning. R6's record lacked documentation of services provided for all services at various times of the day on the following days: December 1, 3, 4, 7-9, 14, 15, and 18, 2022. On December 21, 2022, at 9:56 a.m., director of nursing (DON)-A stated the services were probably provided but not documented. DON-A indicated some staff are not good at taking the time to document. The licensee's 2.80MN Documentation Requirements in Resident Record policy dated May 2022, indicated stall will document services, treatment or therapies provided to each resident. When medications, services, treatments, or therapies are not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living	0 770		

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0 770	Continued From page 7 facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide all-weather walks within the lot lines to the primary entrance. 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) 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). Findings include: On December 19, 2022, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the administrator (A)-D. During the facility tour, survey staff observed an all-weather walk	0 770		

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0 770	Continued From page 8 covered with snow outside the marked exit across from resident room 116. An all-weather walk was not being maintained within the lot lines to the primary entrance. This deficient condition was verified by A-D accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 770		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800		

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0 800	Continued From page 9 or has the potential to affect a large portion or all of the residents). Findings include: On December 19, 2022, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the administrator (A)-D. During the facility tour, survey staff observed the following: 1. Space heaters were plugged into power strips in resident rooms 101 and 118. 2. The space heater in resident room 118 was not listed or marked for safety standards. 3. The smoke alarm had tape adhered to the cover in the mechanical room across from resident room 114. 4. A smoke alarm was hanging loose from the ceiling in resident sleeping room 120. Dementia care unit: 1. The access panel under the fireplace was missing in the dining room. Capped electrical wires were observed underneath the fireplace. A replacement panel was installed on the fireplace during the facility survey on December 19, 2022. 2. One light was not working in the bathing room. 3. Electrical panels were obstructed in the mechanical room. 4. A smoke alarm was hanging loose from the ceiling in resident sleeping room 125. These deficient conditions were verified by A-D accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		

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0 810	Continued From page 10	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 safety and evacuation plan with the required elements; failed to provide required employee training on the fire safety and evacuation plans; failed to provide training on fire safety and evacuation to residents capable of self-evacuation; and failed to complete required employee evacuation drills. 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) 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). Findings include: On December 19, 2022, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the administrator (A)-D. During the facility tour, survey staff observed that posted evacuation plans did not identify the location and number of resident sleeping rooms. On December 19, 2022, at approximately 1:00 p.m., records were provided for review. Records were reviewed by survey staff on December 19, 2022, between 1:00 p.m. and 1:45 p.m. Record review of the available documentation indicated that the licensee had not developed the fire safety and evacuation plans for the facility location. The fire safety and evacuation plans were templates from Encore. The plans reference an evacuation map which was not included with	0 810		

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0 810	Continued From page 12 the plans. Record review of the available documentation indicated that the fire safety and evacuation plans included general employee actions, but the plans did not specify how to move or evacuate residents in the event of a fire or similar emergency from this facility location. Record review of the available documentation indicated that the fire safety and evacuation plans included some fire protection provisions for residents but did not specify procedures for resident movement, evacuation and relocation for this facility location. The plans did not identify unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated that evacuation drills for employees were performed in April and September of 2022. The evacuation drill requirements for employees of twice per year per shift with at least one evacuation drill every other month frequency requirement was not met. On December 19, 2022, at approximately 2:05 p.m., the A-D confirmed during an interview that the licensee had not developed the fire safety and evacuation plans for the facility location and that the evacuation drill frequency had not been met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation	01060		

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01060	Continued From page 13 (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process	01060		

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01060	Continued From page 14 in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R7). 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: R7 started receiving services on May 2, 2022. R7's service plan dated October 12, 2022, indicated R7 received assistance with medication administration, safety checks, housekeeping, and laundry. R7's record indicated R7 went to the emergency room on October 20, 2022, and was admitted to the hospital. R7's record lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider - contact information for the Office of Ombudsman for Long-Term Care - if known and applicable, the approximate date	01060		

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01060	Continued From page 15 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R7's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On December 21, 2022, at 8:50 a.m., administrator (A)-D stated they were not aware of this requirement and have not been sending the required written notice for any residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01710		

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01710	Continued From page 16 (RN) completed an annual medication reassessment for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3 admitted to the facility on September 1, 2020, and began receiving assisted living services on August 1, 2021. R3's service plan dated November 22, 2022, indicated R3 received services to include medication administration. R3's record lacked an annual medication reassessment. On December 21, 2022, at 10:57 a.m., director of nursing (DON)-A was unaware this needed to be completed at least yearly and indicated he/she was still learning the requirements of the position. The licensee's 2.28MN Medication Management Individualized Plan dated September 2022, indicated the medication management record will be current and updated when there were any changes. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions. In addition, the licensee failed to monitor the refrigerator temperature. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 19, 2022, at 11:20 a.m., during a facility tour, the surveyors, in the presence of director of nursing (DON)-A, observed a small medication refrigerator with freezer component within the memory care unit that contained various medications for multiple residents. The surveyor observed a document taped to the cabinet above the refrigerator titled Refrigerator Temperature Log for December 2022. For dates December 1, through 19, 2022, there were no temperatures documented.	01880		

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01880	Continued From page 18 On December 19, 2022, at 11:58 a.m., the surveyors observed one insulin Lispro Kwikpen (fast acting insulin for diabetes) and suppositories (rectal medication) for pain and constipation for multiple residents. The manufacturer's instructions for bisacodyl suppository last reviewed on November 15, 2016, indicated to store in room temperature. The manufacturer's instructions for acetaminophen suppository last reviewed on July 31, 2022, indicated to store in room temperature. The manufacturer's instructions for insulin Lispro Kwikpen last updated on June 16, 2022, indicated before opening store the insulin in the refrigerator. Do not allow insulin to freeze. On December 19, 2022, at 11:20 a.m., DON-A was not aware the thermometer was not working. DON-A stated the battery was corroded inside. DON-A replaced the battery and the refrigerator temperature read 38.5 degrees Fahrenheit/F. DON-A indicated it was expected the unlicensed personnel would check the temperature daily. The licensee's 2.28MN Medication Management Individualized Plan dated September 2022, indicated each resident's individualized medication management record would have a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

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01880	Continued From page 19 days	01880		
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 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 record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability 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) 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). Findings include: On December 19, 2022, at approximately 1:00	02040		

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02040	Continued From page 20 p.m., the administrator (A)-D provided records for review. Records were reviewed by survey staff on December 19, 2022, between 1:00 p.m. and 1:45 p.m. A hazard vulnerability or safety risk assessment for the property was not included in the documentation. The assessment was requested by survey staff but not provided. On December 19, 2022, at approximately 2:05 p.m., the A-D confirmed during an interview that the licensee had not completed a hazard vulnerability or safety risk assessment on and around the property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an awake person was physically present in a secured dementia care unit, 24 hours a day, seven days a week who was responsible for responding to requests of residents for assistance in a secured	02070		

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02070	Continued From page 21	02070		

area. This had the potential to affect all residents in the secured dementia care unit.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On December 19, 2022, during entrance conference at 10:00 a.m., the licensee indicated two people are staffed on the overnight shift. One unlicensed personnel (ULP) is scheduled to work in the locked memory care unit and the other ULP is scheduled to work in the assisted living unit. The licensee also indicated the overnight shift starts at 10:30 p.m. until 6:30 a.m.

On December 19, 2022, during a facility tour at 11:00 a.m., the surveyor observed a large dining area for assisted living residents. To the left, was the assisted living unit which had 11 rooms. Straight ahead from the dining room was another assisted living unit that had 9 rooms. To the right of the dining room, were locked double doors which entered the memory care unit's common area and a hallway for 10 rooms.

On December 20, 2022, at 8:55 a.m., director of nursing (DON)-A stated the ULP from the locked memory care unit would leave the memory care residents alone to assist the other ULP in the assisted living with two person transfers or assist with a fall.

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02070	Continued From page 22 On December 20, 2022, at 9:15 a.m., ULP-B indicated ULPs were trained to have the staff person from memory care assist with getting a resident off the floor or they would contact the non-emergency number for assistance if they could not get the resident off the floor. The licensee's posted "December 16-31 2022" staff schedule indicated two ULPs were scheduled to work overnight daily. The licensee's 1.28MN Staffing Plan dated July 2021, indicated the licensee would ensure staff are available 24-hours a day, seven-days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Additionally, the policy indicated under their conventional staffing model, there would be three awake staff members. No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review by evaluation supervisor on December 21, 2022, however noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Seven (7) days	02070		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date	02310		

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02310	Continued From page 23 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of two residents (R5) who utilized side rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 19, 2022, at 11:15 a.m., during the initial tour with administrator (AD)-D and director of nursing (DON)-A, the surveyors observed a single grab bar in the shape of an upside down "U" on the left side of R5's bed. The surveyor pulled at the grab bar and was able to pull it slightly out with effort. The surveyor asked DON-A if they had the manufacturer's guideline for installation available, he/she indicated the family had that information and would need to ask for it. R5 was admitted to licensee on July 8, 2022. R5's Service Plan Detail dated October 18, 2022, indicated R5 received services including medication management, assistance with bathing, grooming, dressing, transfers, and	02310		

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02310	Continued From page 24 assistance with mobility as needed. R5's Progress Notes dated October 18, 2022, indicated R5's family had requested to place a "bed rail on resident's bed to aid in mobility. They reported he/she did well with it while at a transitional care unit (TCU)." R5's 2.26MN-F Bed Rail Negotiated Risk Agreement dated October 18, 2022, indicated benefits and risks of bed rails were discussed with the resident and resident's representative. R5's medical record lacked an assessment to determine if R5 was a good candidate for a grab bar. R5's medical record also lacked documentation that the grab bar was installed, used, and maintained per manufacturer's guidelines. On December 20, 2022, at 1:55 p.m., the surveyor observed that the grab bar had been removed from R5's bed. The surveyor asked R5 why the grab bar was gone and R5 indicated the licensee told them that "it wasn't safe to use anymore." The surveyor asked if R5 used the grab bar and felt it was useful, R5 indicated "yes." On December 20, 2022, at 1:58 p.m., the surveyor asked DON-A why the grab bar was removed from R5's bed and DON-A indicated they were told to remove it. On December 20, 2022, at 2:00 p.m., surveyor asked regional vice president of operations (RO)-C, regional director of wellness (RDW)-E, and AD-D why the grab bar was removed, and they indicated "based on another survey, they were told the bedrails were not considered FDA approved." The surveyor indicated this grab bar	02310		

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THE ENCORE AT NORTH BRANCH	38610 14TH AVENUE NORTH BRANCH, MN 55056

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02310	Continued From page 25 was a consumer bed rail and educated all three on where to find the information on the Minnesota Department of Health (MDH) website to learn more about what is required for assessments and installation guidelines. The licensee's 2.26 Bed Rails policy dated July 2022, indicated when the licensee is aware a resident is utilizing bed rails on a bed, licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of bed rails, and verify that the bed rail in use of a safe design and utilized consistent with the manufacturer's directions. This policy should be followed regardless of who owns or is supplying the bed rail. Additionally, the licensee would determine if the bed rail is considered to be safe and the bed rail is used consistent with manufacturer's directions. The Food and Drug Administration's (FDA) A Guide to Bed Safety, dated March 10, 2006, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30608	A. BUILDING: _____ B. WING _____	12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT NORTH BRANCH	38610 14TH AVENUE NORTH BRANCH, MN 55056

(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
02310	Continued From page 26 Immediacy is removed as confirmed by review by evaluation supervisor on December 21, 2022, however noncompliance remains at a scope and severity of G. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *12/19/22*
Time: 12:00:01
Report: 1029221400

Food and Beverage Establishment Inspection Report

Location:
Encore at the Twin Cities LLC
38610 14th Avenue
North Branch, MN55056
Chisago County, 13

Establishment Info:
ID #: 0019956
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Encore at the Twin Cities LLC

Phone #: 6516740068
ID #: 53811

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.

3-500D Microbial Control: disposition of food
3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

Opened shredded cheese date marked 12/5. Instructed Vicki to discard any TCS items that exceeded the 7 day limit.

Comply By: 12/19/22

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.

Quaternary ammonium concentration measured ~50 ppm in sanitizer bucket and out of dispenser. Instructed to mix sanitizer by hand until repaired. Establishment has heat sanitizing dishwasher.

Comply By: 12/19/22

4-300 Equipment Numbers and Capacities
4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

No test strips present to test the quaternary ammonium. I provided Vicki with some test strips and let her take a picture of the color chart on the tube to allow them to accurately mix sanitizer until they obtain their own test strips.

Comply By: 12/19/22

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

Dark mold-like buildup in ice machine. Instructed Vicki to clean often enough to preclude the growth of mold or any other kind of buildup.

Comply By: 12/19/22

Surface and Equipment Sanitizers

quaternary ammonium: = 50 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: Yes

quaternary ammonium: = 50 ppm at Degrees Fahrenheit
Location: dispenser
Violation Issued: Yes

hot water: = at 166.8 Degrees Fahrenheit
Location: dishwashing machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: meatloaf
Temperature: 193 Degrees Fahrenheit - Location: hot holding
Violation Issued: No

Process/Item: shredded cheese
Temperature: 39 Degrees Fahrenheit - Location: walk-in cooler
Violation Issued: No

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

This inspection was conducted in conjunction with an HRD survey at The Encore at North Branch located at 38610 14th Avenue, North Branch, MN 55056.

The inspection was conducted in the presence of Vicki Thill, Kitchen Manager and CFPM, and other staff. All issues were discussed with Vicki during and after the inspection. Employee illness reporting and exclusion procedures were also discussed in addition to general food safety practices. All issues were communicated with HRD staff and lead HRD surveyor and Nurse Evaluator, Anna Bohnen, RN,

following the inspection

The kitchen was commercial in nature: tile floors with integral base coving, FRP walls, stainless steel counters, commercial hood with fire suppression, and commercial equipment including a walk-in cooler. The kitchen was clean to sight and touch and visibly in immaculate condition.

The quaternary ammonium ("quat") dispenser was discovered to be to delivering quat at levels that were ineffective at sanitizing. The kitchen was equipped with heat sanitizing dish machine, so all kitchenware was still able to go through a sanitizing step. I informed Vicki that they could use the quat, or a different sanitizer, to mix a sanitizer solution by hand until they were able to have the dispenser repaired. The establishment was also without quat test strips. I provided Vicki with quat test strips and let her take a picture of the color chart so they could mix a sanitizer solution by hand in the interim. During the inspection, Vicki placed a service order with Ecolab to have the dispenser fixed. I instructed Vicki to never mix quat and chlorine products.

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 1029221400 of 12/19/22.

Certified Food Protection Manager: Vicki L. Thill

Certification Number: FM38984 Expires: 01/18/24

Signed: _____

Vicki Thill
Kitchen Manager

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029221400

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	2	Date	12/19/22
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:01
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Encore at the Twin Cities LLC	38610 14th Avenue	North Branch, MN	55056	6516740068

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0019956	Encore at the Twin Cities LLC	Full		H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	IN (OUT) N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	(IN) OUT N/A N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	IN (OUT) N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/20/22

Inspector (Signature) Samuel McClintock