Electronically Delivered

August 29, 2025

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

RE: Project Number(s) SL30353016

Dear Licensee:

On July 21, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 30, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Renee L Anderson

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	R 07/21/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY INITIAL COMMENTS SL#30353016-1 On July 21, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 30, 2025. As a result of the follow-up survey, the licensee is in substantial compliance.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently 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;	{0 480}		

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{0 480}	Continued From page 1 (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	{0 485}		

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{0 485}	Continued From page 2 (a) All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during this survey.	
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time	{0 580}		

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{0 580}	Continued From page 3 of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	{0 580}	Not reviewed during this survey.	
{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:	{0 650}	Not reviewed during this survey.	
{0 775} SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment	{0 775}		

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{0 775}	Continued From page 4 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:	{0 775}	Not reviewed during this survey.	
{0 800} SS=E	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:	{0 800}	Not reviewed during this survey.	
{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	{0 810}		

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{0 810}	Continued From page 5 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{0 980} SS=F	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement provision must not include a choice of law or choice of venue provision. Assisted living contracts must adhere	{0 980}		

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{0 980}	Continued From page 6 to Minnesota law and any other applicable federal or local law. (c) An assisted living facility must not require any resident or the resident's representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. This MN Requirement is not met as evidenced by:	{0 980}	Not reviewed during this survey.	
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	{01370}		

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{01370}	Continued From page 7 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.	
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30	{01440}		

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{01440}	Continued From page 8 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}		
{01610} SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by:	{01610}	Not reviewed during this survey.	
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}	Not reviewed during this survey.	

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{01620}	Continued From page 9 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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	{01620}		

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{01620}	Continued From page 10 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. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	{01640}	Not reviewed during this survey.	

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{01640}	Continued From page 11 the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.	
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; 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:	{02040}	Not reviewed during this survey.	

Electronically Delivered

June 9, 2025

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

RE: Project Number(s) SL30353016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 30, 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.

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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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

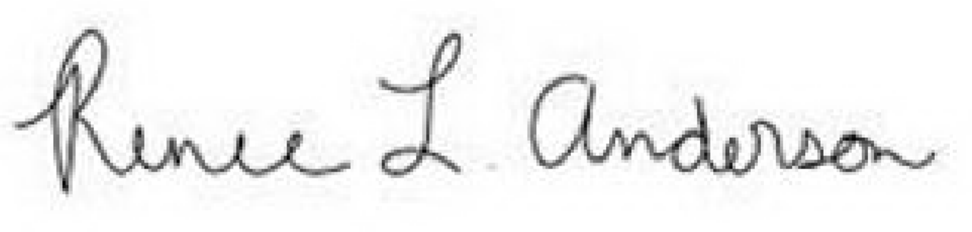
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	04/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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 #30353016-0 On April 28, 2025, through April 30, 2025, 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 17 residents, all of whom were receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 1 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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 2 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 29, 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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0 485	Continued From page 3	0 485		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they did not require a resident to include and pay for meals in the resident contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 28, 2025, at 2:30 p.m., administrator	0 485		

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0 485	Continued From page 4 (A)-A provided the surveyor with the licensee's assisted living contract and identified it as the current contract being use for all residents. The licensee's undated Assisted Living Contract indicated under the Housing section; the basic monthly rent included food service, housekeeping and laundry. The contract did not indicate an option to decline meals provided by the licensee. On April 30, 2025, at 11:40 a.m., A-A stated residents were not able to opt out of meals being included in rent. A-A further stated she thought it was allowed because all the residents required dementia care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced	0 580		

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0 580	Continued From page 5 by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 28, 2025, at 1:35 p.m., administrator (A)-A stated they had not been documenting quality management activity and was not aware of the requirement. The licensee's Quality Management policy, dated July 2021, indicated the licensee, "will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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	0 650		

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0 650	Continued From page 6 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 (clinical nurse supervisor (CNS)-B). 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:	0 650		

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0 650	Continued From page 7 CNS-B was hired December 10, 2024, and provided supervision to staff and direct care services for residents. CNS-B's employee record lacked evidence of the following required content: -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On April 28, 2025, at 2:30 p.m., administrator (A)-A stated CNS-B did not have a job description in her record. A-A further stated it had been her first time hiring a nurse, and she did not realize CNS-B needed one. The licensee's Organization of Personnel Records policy, dated August 2022, indicated all employee records would contain a signed job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=E	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, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code	0 775		

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0 775	Continued From page 8 Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 30, 2025, at 10:35 a.m., the surveyor toured the facility with director of maintenance (DM)-H. During the facility tour, the surveyor observed the following: Controlled Egress Door Locking System - Electromagnetic locks with keypads were installed on the emergency exit doors. A signal or switch was not installed that had the capability to break power to these door locks. During the facility tour interview, DM-H verified the above listed observations. Controlled egress door locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511. - On April 30, 2025, administrator (A)-A and DM-H provided emergency evacuation plan documents. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on April 30, 2025, at 1:10 p.m., A-A verified these instructions were not included in the emergency plan. Space Heaters - In occupied resident room 15, a space heater was turned on with the thermostat set to 75°F (degrees Fahrenheit). - In occupied resident room 3, a space heater that was turned off was plugged into a wall outlet. During the facility tour interview, DM-H verified	0 775		

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0 775	Continued From page 9 the above listed observations and stated they were not aware the use of portable space heaters in dementia care resident rooms was prohibited. Fire Sprinkler Maintenance The 5 year inspection tag for the fire sprinkler system was dated 2017. During the facility tour interview, DM-H stated they did not know if this 5 year inspection had been completed since 2017. On April 30, 2025, DM-H provided a copy of the annual fire sprinkler system inspection report dated February 6, 2025. Record review indicated the 5 year internal inspection was due. Emergency Light Maintenance The emergency lights did not work when tested by DM-H at the west exit door and in the back of the kitchen. During the facility tour interview, DM-H verified these lights did not work. DM-H stated they were aware of the problem and replacement parts had already been ordered. Physical Environment Maintenance In the information technology room, there were holes in the wall where cables had been installed. During the tour interview, DM-H verified the above listed observation and stated firestop was needed to seal the holes. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 30, 2025, at 10:35 a.m., the surveyor toured the facility with director of maintenance (DM)-H. During the facility tour, the surveyor observed the following: 1. Areas of the sidewalk on the front of the building were uneven and chipped, creating a trip/fall hazard. 2. Exterior gazebo - there were exposed screws where wood boards had deteriorated at the base of the gazebo. Several wood boards for the railing were in disrepair, and paint on the structure was peeling. Multiple wood boards were noted with rough surfaces. 3. On the exterior of the building, several of the covers for the intake vents were largely covered by an accumulation of dust and soil. During the tour interview, DM-H verified the above listed observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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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 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	0 810		

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0 810	Continued From page 12 safety and evacuation plan with required content, make all parts of the plan readily available, and provide required training and drills. 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 30, director of maintenance (DM)-H and administrator (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 On April 30, 2025, at 10:35 a.m., the surveyor toured the facility with DM-H. During the facility tour, the surveyor observed emergency evacuation floor plans were not posted in central locations and at the main entrance of the facility for accessibility to all building occupants and emergency responders. Additionally, record review of the available documentation indicated the Encore resident emergency plan, dated February 2022, instructed residents to reference emergency evacuation routes posted in the common areas of the building. During an interview on April 30, 2025, at 1:10 p.m., A-A stated one copy of the emergency floor plan was posted at the resident activity area on the west side of the building.	0 810		

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0 810	Continued From page 13 The FSEP dated February 2022, failed to include the following: The location and number of resident sleeping rooms evident by a review of the FSEP floor plan. Record review of the available documentation indicated the licensee failed to label resident sleeping rooms on the FSEP floor plan in the emergency handbook binder. On April 30, 2025, at 10:35 a.m., the surveyor toured the facility with DM-H. During the facility tour, the surveyor observed numbers were posted at all of the resident sleeping room doors. Sleeping room numbers are required to be included on the fire safety and evacuation floor plan and used with the numbers installed on the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. The FSEP included standard employee procedures and resident evacuation instructions, but failed to provide specific actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by a lack of these site specific procedures in the plan. Record review indicated the FSEP was a template from the Encore at the Twin Cities dated February 2022. Additionally, the plan directed employees to the fire alarm panel as identified on the evacuation map. The provided evacuation map did not label the fire alarm panel location. Evacuation procedures for individualized unique needs of residents had been identified but the licensee failed to maintain these procedures as readily available for all staff accessibility. Record review indicated the FSEP in the emergency handbook binder did not include these identified	0 810		

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0 810	Continued From page 14 resident needs for evacuation. During an interview on April 30, 2025, at 1:10 p.m., A-A stated residents requiring staff assistance in an emergency had been identified as part of the nursing assessments, and these procedures were maintained electronically on the computer. All parts of the FSEP must be maintained as readily available. During an interview on April 30, 2025, at 1:10 p.m., A-A verified the FSEP was lacking and required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year, evident by the lack of documentation. During an interview with A-A on April 30, 2025, at approximately 12:30 p.m., the surveyor requested employee FSEP training records for the past year and one example for a new hire. Fire drill and evacuation response drill forms were provided. During an interview on April 30, 2025, at 1:10 p.m., A-A stated employees participated in fire drills and verified FSEP employee training records were not available. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year, evident by the lack of documentation. During an interview on April 30, 2025, at 1:10 p.m., A-A stated records were not available for resident training on fire safety and evacuation, and they were not aware of this training being offered to residents in the past year. A blank signature page for the Encore resident emergency plan was provided. DRILLS	0 810		

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0 810	Continued From page 15 Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift evident by a review of completed fire drill reports. Eight fire drills were recorded between March 2024 and March 2025, all of these drills were completed during the morning and afternoon shifts. The fire drill response form dated May 14, 2024, at 3:00 p.m., was a combined drill that included both afternoon and night shift employees. During an interview on April 30, 2025, at 1:10 p.m., DM-H stated they were not aware evacuation drills needed to be completed during the night shift and verified the frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 980 SS=F	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract's arbitration agreement did not preclude, limit, or delay the ability of a resident from taking civil action. The licensee further failed to ensure the agreement did not include a choice of venue	0 980		

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0 980	Continued From page 16 provision for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 and R3 were admitted on April 8, 2024, and November 1, 2024, respectively. R2 and R3's Assisted Living contracts, signed April 8, 2024, and November 1, 2024, respectively, each contained an arbitration agreement with the following language limiting the resident's choice of venue: "the arbitration will be conducted at a site selected by Facility which shall be either at Facility or somewhere within a reasonable distance of Facility. The agreement further indicated "any request to arbitrate a dispute must be submitted to AHLA (American Health Lawyers Association) before two (2) years from the date the event giving rise to the dispute occurred. In the event AHLA is unable or unwilling to serve, then the request for Arbitration must be submitted to Facility within (30) thirty days of receiving AHLA 's notice." On April 30, at 11:40 a.m., administrator (A)-A stated she was not aware the arbitration agreement language was not compliant and stated she would let her regional director know. No further information was provided.	0 980		

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0 980	Continued From page 17 TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 980		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study, prior to providing services, for one of 19 employees (unlicensed personnel (ULP)-G). 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	01290		

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01290	Continued From page 18 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-G was hired on January 1, 2025, and provided direct care services to the licensee's residents. The licensee's employee schedule for April 6, 2025, through April 19, 2025, and April 20, 2025 through May 3, 2025, indicated ULP-G worked the overnight shift on April 11, 12, 15, 18, 19, 20, and the evening shift on April 8-13, 15, and 17. The schedule further indicated ULP-G was scheduled to work April 29, 30, May 1, 2, and 3. ULP'G's employee record lacked evidence of a cleared background study completed prior to having direct contact with residents. On April 29, 2025, at 1:50 p.m., the surveyor observed the licensee's DHS NETStudy 2.0 background study roster online with Administrator (A)-A. The NETStudy 2.0 website indicated ULP-G had not completed their consent disclosure and did not have a cleared background study. A-A stated she thought ULP-G had completed their background study and would have them "go online today to complete the consent disclosure." The licensee's 5.24 Background Check Policy Corporate Office, dated September 2022, indicated "all offers of employeement at [licensee] are contingent upon clear results of a thorough background check." No further information was provided.	01290		

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01290	Continued From page 19 TIME PERIOD FOR CORRECTION: Immediate	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370		

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01370	Continued From page 20 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired September 19, 2024, and provided direct care services to residents. On April 29, 2025, at 7:55 a.m., ULP-D was observed assisting the licensee's residents with morning cares. ULP-D's employee record lacked the following required trainings and competency evaluations: -documentation requirements for all services provided; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural	01370		

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01370	Continued From page 21 background and family; and -understanding appropriate boundaries between staff and residents and the resident's family. On April 29, 2025, at 1:26 p.m., administrator (A)-A stated she was not sure why training items were not assigned, and they should have been. A-A stated the regional nurse would talk to human resources to get them assigned. The licensee's 5.48 Competency Training MN policy, dated February 2022, indicated the licensee's training and competency evaluations of ULP would contain all the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing	01440		

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01440	Continued From page 22 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D and ULP-E were hired September 19, 2024, and October 6, 2024, respectively, and provided direct cares for the licensee's residents. On April 29, 2025, at 7:55 a.m., ULP-D was observed assisting residents with morning cares. On April 29, 2024, at 7:45 a.m., the surveyor observed ULP-E assisting R2 with medication administration.	01440		

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01440	Continued From page 23 ULP-D and ULP-E's records both lacked documentation the RN conducted direct supervision of the ULP performing a delegated task within 30 days of performing the task. On April 29, 2025, at 11:29 a.m., administrator (A)-A stated she was unable to find documentation of the 30-day supervisions and she thought they did not get done by the previous nurse who quit abruptly. The licensee's 5.48 Competency Training Evaluations MN policy, dated February 2022, indicated supervision of unlicensed personnel would be conducted within 30 calendar days after the individual begins working for the licensee and first performs delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected	01610		

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01610	Continued From page 24 circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of three residents (R2) on or before the admission date. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted April 8, 2024. R2's service plan, dated August 23, 2024, indicated R2 received services including assistance with medication administration. On April 29, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-E assisting R2 with medication administration. R2's record lacked evidence of an RN assessment of the physical and cognitive needs of the resident, completed prior to contract signing or move in date.	01610		

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01610	Continued From page 25 On April 29, 2025, at 1:15 p.m., clinical nurse supervisor (CNS)-B stated she was unable to locate R2's initial physical and cognitive needs assessment. CNS-B further stated it may be in the licensee's previous electronic medical record (EMR), but she did not have access to that EMR. The licensee's 6.01 Assessments, Reviews & Monitoring policy, dated February 2021, indicated "[licensee] will conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a community or the date on which a prospective resident moves in, whichever is earlier." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
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	01620		

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01620	Continued From page 26 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initiation of services for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted April 8, 2024. R2's service plan, dated August 23, 2024, indicated R2 received services including assistance with medication administration. On April 29, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-E assisting	01620		

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01620	Continued From page 27 R2 with medication administration. R2's record lacked a resident reassessment and monitoring conducted no more than 14 calendar days after initiation of services. On April 29, 2025, at 1:15 p.m., clinical nurse supervisor (CNS)-B stated she was unable to locate the 14-day reassessment for R2. CNS-B further stated it may be in the licensee's previous electronic medical record (EMR), but she did not have access to that EMR. The licensee's 6.01 Assessments, Reviews & Monitoring policy, dated February 2021, indicated the resident reassessment and monitoring would be conducted no more than 14 days after the initiation of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	04/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 28 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted April 8, 2024, with diagnoses including dementia. R2's service plan, dated August 23, 2024, indicated R2 received services including assistance with medication administration. On April 29, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-E assisting R2 with medication administration.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	04/30/2025

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

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01640	Continued From page 29 R2's record included a service plan, dated April 9, 2024, authenticated by regional nurse supervisor (RN)-I, but lacked authentication by the by the resident or resident representative documenting agreement on the services to be provided. On April 30, 2025, at 10:30 a.m., RN-I stated he had signed the service plan, dated April 9, 2024, but he was not sure why it was never signed by R2's representative. The licensee's 2.08 MN Service Plan policy dated July 2021, indicated a finalized service plan would be completed no later than 14 days after initiation of services, and would include a signature or authentication by the licensee and by the resident or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	04/30/2025

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

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02040	Continued From page 30 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to complete a safety risk or hazard vulnerability assessment of the physical environment with mitigation factors. This had the potential to directly affect all dementia care residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During an interview on April 30, 2025, at approximately 12:30 p.m., with administrator (A)-A, the surveyor requested a copy of a safety risk or hazard vulnerability assessment of the physical environment with mitigation factors. A-A stated a copy of this assessment was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

The Encore at Hugo
5607 150th Street N
Hugo, MN 55038
Washington County
Parcel:

Phone:

License Info

License: HFID 30353

Risk:
License:
Expires on:
CFPM: Mindy LaClair
CFPM #: 28114; Exp: 8/25/2025

Inspection Info

Report Number: F1031251003
Inspection Type: Full - Single
Date: 4/29/2025 Time: 08:30:00 AM
Duration: 90 minutes
Announced Inspection: No
Total Priority 1 Orders: 4
Total Priority 2 Orders: 4
Total Priority 3 Orders: 3
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: **ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE.**

COPY OF LOG SENT WITH REPORT. PRINT AND KEEP ILLNESS LOG ON SITE.

FILL OUT LOG WHENEVER SOMEONE CALLS IN OR GOES HOME SICK.
Comply By: 4/29/2025 Originally Issued On: 4/29/2025

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: OBSERVED RAW EGGS STORED ABOVE ONIONS IN WALK-IN COOLER.

HAD STAFF MOVE EGGS TO BOTTOM SHELF.

REFRIGERATION STORAGE DIAGRAM SENT WITH REPORT.

PRINT AND POST DIAGRAM IN KITCHEN AND/OR WALK-IN COOLER.
Comply By: Complied On Site Originally Issued On: 4/29/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: MILK IN ICE BATH MEASURED 44F.

MILK PLACED IN WALK-IN COOLER.

DISCONTINUE USING ICE BATH TO HOLD PRODUCTS GOING BACK INTO COLD-HOLDING.

USE PITCHER WITH SMALL AMOUNT OF MILK AS WORKING STOCK. FILL AS NEEDED. DISCARD REMAINING AFTER SERVICE.
Comply By: Complied On Site Originally Issued On: 4/29/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.
COMMENT: IRREVERSIBLE THERMOMETER MAY NOT BE DISPLAYING CORRECT TEMP.

CALIBRATE IRREVERSIBLE THERMOMETER IF POSSIBLE.

IF UNABLE TO CALIBRATE, PURCHASE NEW IRREVERSIBLE THERMOMETER.
Comply By: 5/2/2025 Originally Issued On: 4/29/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: STAFF COULD NOT FIND SANI TEST KIT.

FIND OR PURCHASE TEST KIT (SHOULD HAVE BOTH BLEACH AND QUAT TESTING KITS ON SITE).

MAKE SURE ALL STAFF KNOW LOCATION OF TEST KIT.
Comply By: 5/2/2025 Originally Issued On: 4/29/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.116 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.
COMMENT: STAFF IS NOT CHECKING SANITIZER CONCENTRATION.

STAFF MUST CHECK SANITIZER DISPENSER CONCENTRATION WITH SANI STRIPS ON REGULAR BASIS.

RECOMMENDED: CHECK CONCENTRATION DAILY SINCE THERE HAVE BEEN PAST ISSUES WITH SANI DISPENSER.
Comply By: 5/2/2025 Originally Issued On: 4/29/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: SHELF IN WALK-IN TO LEFT OF FREEZER DOOR RUSTED WITH CHROME PLATING PEELING OFF.

DISCONTINUE USE OF SHELF DUE TO RISK OF PHYSICAL CONTAMINATION.

REPLACE SHELF WITH ANSI-APPROVED (NSF OR SIMILAR) SHELVING.
Comply By: 5/20/2025 Originally Issued On: 4/29/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: **CAN OPENER FOUND WITH FOOD BUILDUP ON BLADE.**

HAD CAN OPENER SENT TO DISH FOR CLEANING.

CHECK CAN OPENER FOR BLADE DEBRIS PRIOR TO USE AND CLEAN CAN OPENER AFTER USE DAILY.
Comply By: Complied On Site Originally Issued On: 4/29/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11C *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.
COMMENT: SANITIZER DISPENSER MEASURED 0PPM.

DISCONTINUE USE OF DISPENSER UNTIL REPAIRED.

STAFF MADE SANI BUCKETS BY HAND AND TESTED BETWEEN 150-400PPM QUAT.

CONTACT INSPECTOR ONCE REPAIRED.
Comply By: 4/29/2025 Originally Issued On: 4/29/2025

New Order: 5-200A Plumbing: approved materials/design
5-201.11B *Priority Level: Priority 3 CFP#: 51*
MN Rule 4626.1040B Maintain the plumbing system in good repair.
COMMENT: LEVER WASTE ON 3-COMP LEFT BASIN IS LEAKING.

REPAIR OR REPLACE LEVEL WASTE.
Comply By: 5/20/2025 Originally Issued On: 4/29/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: OBSERVED MULTIPLE HOLES, ANCHORS, SCREWS, AND NAILS IN WALLS THROUGHOUT KITCHEN.

ASKED STAFF TO MARK ALL HOLES, ANCHORS, SCREWS, AND NAILS WITH TAPE FOR EASY VISIBILITY.

HAVE MAINTENANCE REMOVE ANCHORS, SCREWS, AND NAILS AND FILL HOLES WITH 100% SILICONE.
Comply By: 5/20/2025 Originally Issued On: 4/29/2025

Food & Beverage General Comment

Nurse Evaluator on site: Tammy Carlson

All violations discussed with PIC prior to leaving site.

Discussed:
- Cooling procedure
- Pasteurized eggs
- Thermometer use and calibration
- Working Stock
- Checking sani cncentration (150-400ppm Quat, 50-200ppm Chlorine)

Facility has a full commercial kitchen.

NOTE: HAVE MAINTENANCE CHECK TO SEE IF A FILTER IS MISSING FROM THE VENTILATION SYSTEM BLOWING INTO KITCHEN ON WALL NEXT TO PEGBOARD.

ILLNESS COMPLAINT PROCEDURE:
If any customer complains of illness take these steps:
1. Gather as much information from the customer as possible, such as: name, phone#, date of illness, food consumed.
2. Give customer the illness hotline phone number: 1-877-366-3455.
3. Contact your health inspector: Give inspector information gathered from customer and any other useful information.

Contact inspector prior to any major equipment or building changes; some changes may require plan review to be completed.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1031251003 from 4/29/2025

Tery Brekke
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

The Encore at Hugo
Hugo
County/Group: Washington County

Inspection Info

Report Number: F1031251003
Inspection Type: Full
Date: 4/29/2025
Time: 08:30:00 AM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Ice Tray on Counter at 44 Degrees F.
Comment:
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: Ambient **; Temperature Process:** Static Equipment
Location: Walk-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Chili**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Eggs**; Temperature Process:** Hot-Holding
Location: Steam Table at 143 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Oatmeal**; Temperature Process:** Hot-Holding
Location: Steam Table at 154 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

The Encore at Hugo
Hugo
County/Group: Washington County

Inspection Info

Report Number: F1031251003
Inspection Type: Full
Date: 4/29/2025
Time: 08:30:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
Location: Dishwashing Area **Equal To** 167 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Auto-Mix Dispenser
Location: 3-Compartment Sink **Equal To** 0 PPM
Comment: Possible hard water issue causing blockage.
Consider in-line hard water removal system.
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Manual Mix
Location: Kitchen **Equal To** 400 PPM
Comment: Sani Bucket
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Pre-Mixed Solution
Location: Waitress Station **Equal To** 300 PPM
Comment: Sani Bucket
Violation Issued?: No