Electronically Delivered

April 12, 2022

Administrator
Empowerment Healthcare
112001 Hidden Creek Place
Chaska, MN 55318

RE: Project Number(s) SL20397015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 17, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20397	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWERMENT HEALTHCARE	112001 HIDDEN CREEK PLACE CHASKA, MN 55318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL20397015 On March 15, 2022, through March 17, 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 was one resident receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license, effective August 1, 2021. The licensee was licensed for a resident capacity of 5 residents and had a current census of 1 resident. During the entrance conference on March 16, 2022, at approximately 10:50 a.m., licensed assisted living director (LALD)-C explained how the licensee staffed its building. LALD-C stated he developed a staffing schedule monthly but had not developed a staffing plan and questioned what a staffing plan was. The surveyor explained what a staffing plan was and LALD-C reiterated the licensee had not developed a staffing plan. The licensee's Staffing policy, dated August 1, 2021, indicated the clinical nurse supervisor would prepare and implement a twenty-four (24) hour daily staffing plan that would ensure adequate staffing to meet resident needs at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 3 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 and served according to the Minnesota Food Code. This had the potential to affect all residents in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated March 15, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 580		

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0 580	Continued From page 5 During an interview on March 15, 2022, at 11:55 a.m., licensed assisted living director (LALD)-C stated he conducted staff meetings frequently to discuss resident care and concerns; however, had not developed any quality management activities. The licensee's quality management policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for one of one	0 630		

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0 630	Continued From page 6 residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on November 3, 2021. R1's medical record indicated a diagnosis of a traumatic brain injury. R1's IAPP dated November 3, 2021, that identified R1's vulnerabilities a history of physical abuse, sexual abuse, emotional abuse, and self harm. R1's IAPP did not include specific measures to be taken by staff to minimize the risk of abuse to R1 with identified vulnerabilities. On March 16, 2022, at approximately 12:21 p.m., registered nurse (RN)-A verified R1's IAPP was not updated to reflect R1's current vulnerabilities with interventions to minimize the risk of abuse. RN-A stated that documentation of interventions had been communicated in R1's services and behavioral plans. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, indicated the IAPP would include specific measures to minimize the risk of abuse. No further information provided.	0 630		

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0 630	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=C	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (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;	0 730		

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0 730	Continued From page 8 (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 provide written acknowledgement of receipt of the current Minnesota Assisted Living Bill of Rights (BOR) for one of one residents (R1) with records reviewed. 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: R1's record lacked written acknowledgement for the current assisted living BOR dated May 2021. On March 15, 2022, at approximately 10:45 a.m.., licensed assisted living director (LALD)-C acknowledged that R1 did have a current BOR, but lacked documentation noting R1 had received a current BOR.	0 730		

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0 730	Continued From page 9 The licensee lacked a current policy for resident acknowledgement of the Minnesota Assisted Living Bill of Rights. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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.	0 810		

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0 810	Continued From page 10 (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, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on March 17, 2022, at approximately 9:50 a.m. with Licensed Practical Nurse (LPN)-D, House Manager (ULP)-B, and Property Manager (PM)-E on the fire safety and evacuation plan and fire safety and evacuation training for the facility. Record review indicated that the fire safety and evacuation plan did not have employee actions to be taken in the event of a fire or similar emergency. During interview, ULP-B stated that the fire safety and evacuation plan did not have	0 810		

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0 810	Continued From page 11 provisions for this requirement. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, ULP-B stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, ULP-B stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, ULP-B stated that the licensee provides training to employees on fire safety at initial hire only. ULP-B was not able to provide a policy on this. Record review indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. During interview, ULP-B stated that the licensee does not provide this training to residents. ULP-B was not able to provide a policy on this. Record review indicated that that the licensee did not have documentation indicating that evacuation drills had been conducted every other month as required. During interview, ULP-B	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 12 stated that the licensee had not conducted any evacuation drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20397	A. BUILDING: _____ B. WING _____	03/17/2022

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01530	Continued From page 13 licensee failed to ensure one of one employee (unlicensed personnel (ULP)-B) received the required amount of dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B's hire date was October 4, 2021. ULP-B did not have had eight (8) hours of dementia training within 120 working hours of the employment start date. During interview on March 15, 2022, at approximately 1:15 p.m., licensed assisted living director (LALD)-C stated all employees received dementia training through a online education system. LALD-C stated all new employees are to receive eight hours of dementia training upon hire. ULP-B's education record noted one hour of dementia training. During interview on March 15, 2022, at approximately 1:45 p.m., ULP-B verified that she had only received one hour of dementia training at the time of hire. The licensee's Assisted Living Dementia Training policy, dated August 1, 2021, indicated direct care staff would completed eight hours of initial training in dementia care within one hundred	01530		

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01530	Continued From page 14 twenty hours of employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included the method of supervision and monitoring of staff for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on November 3, 2021. R1's diagnoses included major depressive disorder, attention deficit disorder, anxiety, opioid dependence. R1 required assistance with medication administration. R1's service plan dated November 3, 2021, lacked the method of supervision and monitoring of staff. During interview on March 15, 2022, at 1:45 p.m., licensed assisted living director (LALD)-C indicated he was not aware the service plan lacked the method of supervision and monitoring of staff. The licensee's Service Plan policy dated August 1, 2021, indicated a service plan would include a schedule and method for the next planned monitoring of staff providing services. No further information was provided.	01650		

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01650	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	01730		

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01730	Continued From page 17 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1's service plan dated November 3, 2021, indicated medication administration was assigned to unlicensed personnel (ULP), registered nurse (RN), and licensed practical nurse (LPN). R1's Individualized Medication Management Plan dated November 3, 2021, lacked written procedures for ULPs to notify a RN or appropriate licensed health professional when a problem arises.	01730		

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01730	Continued From page 18 During interview on March 15, 2022, at 11:30 a.m., licensed assisted living director (LALD)-C stated there are no specific instructions for when ULPs should report changes to a nurse in the medication management plan. LALD-C stated he was not aware this was not included in the plan. The licensee's Medication Management Individualized Plan policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	01820		

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01820	Continued From page 19 has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on November 3, 2021, with diagnoses including traumatic brain injury, attention deficit disorder, opioid abuse. R1's medication administration record dated November 3, 2021, indicated R1 received medication administration services of oral medications. R1's medical record lacked signed prescriber's orders for each medication that R1 received. During an interview on March 16, at 12:20 p.m., registered nurse (RN)-A indicated R1 received medication administration services. RN-A acknowledged that R1's medical record lacked signed prescription orders. The licensee's Medications and Treatments policy dated August 1, 2021, stated written prescriber orders are required for medications or treatments provided to a resident. The policy also indicated an order for medications or treatments must be dated, signed by a prescriber, and must be current and consistent with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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

Type: Full
Date: *03/15/22*
Time: 14:15:54
Report: 1021221045

Food and Beverage Establishment Inspection Report

Location:
Empowerment Healthcare
112001 Hidden Creek Place
Chaska, MN55318
Carver County, 10

Establishment Info:
ID #: 0037708
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7635660831
ID #:

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

The following orders were issued during this inspection.

7-200 Toxic Supplies and Applications

7-204.11 ** Priority 1 **

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE BLEACH FOUND ON-SITE IS SCENTED AND IT IS NOT FOR SANITIZING FOOD CONTACT SURFACES. DISCONTINUE USING SCENTED BLEACH AND PROVIDE A BLEACH THAT CAN BE USED TO CLEAN AND SANITIZE FOOD CONTACT SURFACES.

Comply By: 03/15/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE. THERMOLABELS WERE LEFT ON-SITE. SEE COMMENTS.

Comply By: 03/22/22

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 KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 03/22/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

UNDER MICROWAVE CONTAINS ACCUMULATION OF GREASE. DUST AND DEBRIS INSIDE WOOD CABINETS. CLEAN AND MAINTAIN CLEAN.

Comply By: 03/18/22

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH OWNER ROGER BONNY.

ESTABLISHMENT CURRENTLY HAS ONLY ONE CLIENT. THE ESTABLISHMENT CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH STAFF, THEIR CLIENT IS INDEPENDENT AND THEY CAN COOK AND CLEAN AFTER THEMSELVES. NO FOOD EMPLOYEES ARE CURRENTLY WORKING IN THE KITCHEN.

ESTABLISHMENT PROVIDES THE FOOD, BUT THE CLIENT CAN ALSO BUY THEIR OWN GROCERIES. THEIR CURRENT CLIENT GOES ONCE A WEEK TO BUY THEIR OWN GROCERIES.

THERE IS A RESIDENTIAL DISHWASHER ON-SITE. DISHWASHER DOES MEET THE REQUIREMENTS OF THE NSF/ANSI STANDARD 184.

CONTINUATION OF MN Rule 4626.0710B : THE THERMOLABELS WILL HELP THE ESTABLISHMENT VERIFY THAT THEIR DISH MACHINE IS PROVIDING AN ACCURATE FINAL UTENSIL SURFACE TEMPERATURE.

ALTHOUGH THERE ARE NO FOOD EMPLOYEES CURRENTLY WORKING IN THE KITCHEN, DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH OWNER. AN MDH EMPLOYEE ILLNESS LOG WAS SENT WITH REPORT.

DISCUSSED THE REQUIREMENTS FOR THE CERTIFIED FOOD PROTECTION MANAGER (CFPM) CERTIFICATE. ESTABLISHMENT IS WORKING ON GETTING STAFF STATE CERTIFIED. ESTABLISHMENT NEEDS A CFPM AS SOON AS THEY START COOKING AND TAKING CONTROL OF THE FOOD FOR THEIR CLIENTS.

THE CEILING IN THE KITCHEN HAS A POPCORN FINISH, LAMINATE COUNTERS, WOOD CABINETS, LAMINATE FLOORS, AND UNABLE TO VERIFY IF THE BASE CABINETS IN THE KITCHEN WERE NOT HOLLOW. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021221045 of 03/15/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
ROGER BONNY
OWNER

Signed:_____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us