Electronically Delivered

January 7, 2025

Licensee
Empowerment Healthcare
112007 Hidden Creek Place
Chaska, MN 55318

RE: Project Number(s) SL20396015

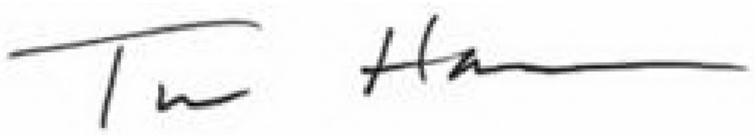
Dear Licensee:

On December 3, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 18, 2024, survey were corrected. 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,



Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 23, 2024

Licensee
Empowerment Healthcare
112007 Hidden Creek Place
Chaska, MN 55318

RE: Project Number(s) SL20396015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 2024, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20396	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWERMENT HEALTHCARE	112007 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 ******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: SL20396015-0 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; all receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 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 observation, interview, and document review, the licensee failed to post a daily work schedule that clearly identified the staff scheduled for the facility. In addition, the facility failed to develop a staffing plan that included an evaluation to determine staffing levels to meet the scheduled and unscheduled needs of all residents. This had the potential to affect the current residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living facility license. The facility was licensed for seven residents and had a current census of three residents. The facility was attached to another assisted living facility, owned by the same licensee, separated by a door. The licensee also owned the building next door to this facility, with two facilities separated by a door. Each of the four assisted living facilities had their own Health Facility Identification number (HFID). One staff was assigned to provide services to the residents in each building, consisting of two facilities. DAILY WORK SCHEDULE On September 16, 2024, at 12:30 p.m., during a tour of the facility with licensed assisted living director in residency (LALDR)-B, the surveyor observed a staffing schedule posted on the bulletin board in the dining room area of the facility. The [name of the group of four assisted living facilities owned by the licensee] September 2024 schedule was color coded and dated Monday, September 9, 2024, through September 22, 2024. On September 16, 2024, the schedule included one staff name with each shift noted, and were color coded, as follows: - 7:00 a.m. through 5:00 p.m. (red);	0 470		

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0 470	Continued From page 3 - 7:00 a.m. through 3:00 p.m. (yellow); - 3:00 p.m. through 11:00 p.m. (red); - 5:00 p.m. through 11:00 p.m. (red); - 11:00 p.m. through 7:00 a.m. (yellow); and - 11:00 p.m. through 7:00 a.m. (green). The schedule did not identify the facility that coincided with each color. On September 16, 2024, at 1:31 p.m., an unidentified unlicensed personnel (ULP) stated the ULPs no longer followed the color-coded system for work assignment and would decide between themselves which facility they would work at for their shift. On September 16, 2024, at 1:36 p.m., LALDR-B stated ULPs should be following the color-coded system for staff assignment and provided the surveyor with a piece of paper that indicated the color on the schedule and which facility the color coincided with. LALDR-B stated the staff scheduled for this facility also provided services for the residents in the attached facility. Although the daily work schedule was posted, staff were not following the schedule by working in their assigned facility, and there was no indication of what color coincided with which facility. STAFFING PLAN The Staffing Plan, dated August 30, 2024, indicated the facility was staffed at a "1 [one staff] to 6 [six residents] ratio," and indicated one full time staff worked Monday through Friday, 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. The plan also indicated one part time staff worked weekends (Saturday and Sunday) from 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m.	0 470		

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0 470	Continued From page 4 The plan indicated, "As of 08/30/2024 [August 30, 2024] this plan meets the current client's service needs." The plan lacked information to include the one staff per shift also provided services to the residents in the attached facility, which also currently included three residents. The licensee had a previous staffing plan, dated December 1, 2023, which indicated the licensee was staffed at a "1 to 4 ratio," lacking information to include the one staff per shift also provided services to the residents in the attached facility. On September 16, 2024, at 1:41 p.m., LALDR-B reviewed the facility staffing plan with the surveyor. LALDR-B stated she and clinical nurse supervisor (CNS)-C "talked" about the staffing plan and CNS-C developed the plan; however, LALDR-B stated she was not aware of evidence of an evaluation for the appropriateness of the staffing levels in the facility. On September 17, 2024, at 6:30 a.m., ULP-I stated she "covers [works in]" the two attached facilities during her shift, and stated the door between the two is "always open." During an interview on September 18, 2024, 10:08 a.m., CNS-C stated she looked at the residents' needs when developing the staffing plan, and if a resident was not ambulatory or needed assistance with ambulation, or had an increase in behaviors, they would possibly need two staff to mitigate the issue. When asked about recent resident-to-resident altercations, CNS-C stated they would close and lock the door between the two facilities to keep residents safe; however, could not explain how residents' needs would be met if the staff was in the attached facility with the door locked. CNS-C stated the	0 470		

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0 470	Continued From page 5 part-time weekend staff listed on the staffing plan were not "extra" staff, but could be hired as "part-time staff." CNS-C stated the licensee did not have evidence of an evaluation to determine the needs of the residents to ensure that staffing levels were adequate to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy, reviewed January 3, 2022, indicated the clinical nurse supervisor would develop a 24-hour daily staffing schedule to include direct care staff work schedules for each direct care staff member, indication of all work shifts, including days and hours worked, and identify direct care staff member's resident assignments or work location. The posted daily work schedule would be posted in each building of a facility or campus accessible to staff, residents, volunteers, and the public. The policy also directed a clinical nurse supervisor, or designee, would develop, write, and implement a staffing plan that would provide qualified direct-care staff sufficient to meet the residents'	0 470		

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0 470	Continued From page 6 needs 24-hours a day, seven days a week, and would be adequate to address: - each resident's needs as identified in the service plan and assisted living contract; - each resident's acuity level as determined by the most recent assessment or individualized review; - ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises; and - staff competency and training. The staffing plan would be evaluated for the appropriateness of the staffing levels in the facility and revised as needed at a minimum of two times per year. 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 following services to residents: (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 practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 7 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 September 16, 2024, 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		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon	0 490		

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0 490	Continued From page 8 individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect the licensee's three current 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 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 the entrance conference on September 16, 2024, at 11:11 a.m., licensed assisted living director in residency (LALDR)-B, owner (O)-A, and licensed practical nurse (LPN)-G stated the licensee provided assistance with transportation, arranging appointments, shopping, accessing community resources, a daily program of social and recreational activity, and provided culturally sensitive programs. On September 16, 2024, at 12:21 p.m., during a facility tour with licensed assisted living director in	0 490		

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0 490	Continued From page 9 residency (LALDR)-B, the surveyor did not observe an activities calendar posted. During an interview on September 17, 2024, at 6:55 a.m., when asked what the residents do for fun, R1 stated, "Everybody just sleeps. Most people just stay in their rooms. I wish we had one activity. There's nothing to do. I'm bored out of my mind." During an interview on September 17, 2024, at 8:15 a.m., R3 stated he spent most of the time alone in his room, watching television, and liked to ride bike and spend time outdoors, although stated that was going to be difficult with winter coming. R3 stated the residents in the facility "pretty much" stayed to themselves and in their rooms. R3 stated he was "bored" at times. During an interview on September 17, 2024, at 8:32 a.m., R4 stated there weren't any group activities planned, but R4 enjoyed taking walks and reading about United States history. R4 stated, "I love to go out and do things, but transportation is tough, and I can't afford to pay for it." On September 18, 2024, at 9:31 a.m., the surveyor observed an undated Activity Calendar, posted in the common area of the attached facility with unlicensed personnel (ULP)-H. ULP-H stated she had not seen that activity calendar prior to now, adding the activity calendar "must be new." ULP-H reviewed the undated activities calendar with the surveyor and noted the following: -Sunday: read the paper, current events -Monday: cards -Tuesday: crafts, coloring, painting -Wednesday: crossword, word search -Thursday: board games	0 490		

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0 490	Continued From page 10 -Friday: movie night -Saturday: puzzles. The same activities were listed, as described above, six times, indicating six weeks. ULP-H said the activities listed were "not geared for them [residents]" and stated, "They [residents] don't want to do what is on here. They don't want to do that stuff." ULP-H stated the activity calendar should be developed by talking to the residents and finding out what they would like to do. Throughout the survey on September 16, 2024, through September 18, 2024, the surveyor observed residents remained in their rooms, except to come to the dining room to eat meals or to take meals back to their rooms, or to go to the restroom. Occasionally, one resident was in the common area, with the television on. Facility staff did not interact with residents, except when administering medications. The surveyor observed no activities offered. On September 18, 2024, at 10:51 a.m., LALDR-B stated the house manager had recently quit and she was in charge of the activities for the residents. LALDR-B stated activities were important for residents and stated this needed to be looked at. The licensee's Residents Activities policy, reviewed January 3, 2024, indicated recreational opportunities would be offered based on the interests of the residents. Also included "The assisted living statue requires that a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large was offered."	0 490		

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0 490	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). This included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (registered nurse (RN)-E). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 12 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 the entrance conference on September 16, 2024, at 11:11 a.m., a request was made to review the facility TB risk assessment. The TB risk assessment provided was dated May 8, 2024, and indicated the licensee's TB risk level was "low." RN-E had a hire date of January 2, 2024, to provide services and supervision under the licensee's Assisted Living license to the licensee's residents and staff. RN-E's employee record included a Baseline TB Screening Tool for Health Care Personnel (HCPs), dated December 5, 2023, and included results of a negative TST, dated December 19, 2022, and results of a second negative TST, dated January 9, 2023, not within 90 days of being hired by the licensee, as required. RN-E's record also included handwritten results of a TB blood test, indicating the laboratory results were "negative," and another handwritten note that indicated these results were by patient history, in approximately 2020. On September 17, 2024, at 11:32 a.m., licensed assisted living director in residency (LALDR)-B stated RN-E was employed by the licensee, left her position, and was rehired in January, 2024, so	0 660		

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0 660	Continued From page 13 they used her TB results from her previous employment with the licensee. LALDR-B stated RN-E should have completed a two-step TST or other evidence of TB screening such as a blood test when she was rehired. The licensee's TB Prevention and Control policy, reviewed January 3, 2022, indicated the clinical nurse supervisor was responsible for screening of assisted living staff for TB, and would maintain all reports of TB screening in the personnel files of assisted living employees. The policy indicated the facility would follow the guidelines provided by the Minnesota Department of Health (MDH) related to the risk assessment and the frequency of screening for all employees and volunteers, including at the time of hire and prior to any contact with residents. If the first step TST was negative, and was dated within 90 days before hire, the employee may begin working with residents. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the	0 660		

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0 660	Continued From page 14 HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 15 by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan (EPP) with all of the required content defined in Appendix Z and failed to post an emergency preparedness plan prominently. In addition, the licensee failed to evaluate the missing resident plan at least quarterly. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on September 16, 2024, at 11:11 a.m., assisted living director in residency (LALDR)-B stated the facility's EPP was in a red binder, in the locked medication storage room, and staff were trained to know where the binders were located. During a facility tour with licensed assisted living director in residency (LALDR)-B, on September 16, 2024, at 12:33 p.m., LALDR-B located the red binder in the locked medication storage room. There was no evidence of signage posted or information regarding the licensee's emergency plan, and the emergency preparedness plan was not posted prominently, as required. The licensee's EPP, last reviewed January 31,	0 680		

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0 680	Continued From page 16 2024, failed to include the following: - a missing resident plan that was reviewed quarterly - procedures for tracking of staff and residents. On September 16, 2024, at 3:04 p.m., via email, owner (O)-A indicated that the missing person policy was reviewed annually, not quarterly as required. On September 16, 2024, at 3:17 p.m., via email, O-A indicated the licensee did not have a complete strategy of tracking on duty staff and residents, as required. The licensee's Emergency and Disaster Preparedness policy, reviewed July 1, 2023, indicated the licensee had developed and implemented emergency preparedness policies and procedures in compliance with 42 C.F.R. 483.73(c) and a written policy and procedure regarding missing residents was completed in compliance with MN Rule 4659.0110; however, the policy lacked direction to review the missing person plan at least quarterly and document any changes to the plan, as required. In addition, the policy indicated the facility would post the emergency disaster plan prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be	0 690		

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0 690	Continued From page 17 current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain records for each resident, with resident record entries authenticated with the name and title of the person making the entry, for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included traumatic brain injury, type 2 diabetes, cardiomyopathy (disease of the heart muscle), and West Nile encephalitis (inflammation of the brain caused by mosquito bite). R1's Assisted Living Service Plan (SP), dated June 3, 2024, indicated R1 required assistance with rooming, bathing, medication administration, orientation management, anxiety management, withdrawal/isolation, socialization, money management, meals, shopping, assistance making appointments, transportation, housekeeping, and laundry.	0 690		

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0 690	Continued From page 18 R1's Progress Notes, dated March 1, 2024, through August 16, 2024, printed September 17, 2024, included the following: - entry on March 8, 2024, at 11:11 a.m., signed with licensed practical nurse (LPN)-G's name, followed by "nurse" - entry on March 12, 2024, at 11:21 a.m., signed with LPN-G's name, followed by "nurse" - entry on March 12, 2024, at 12:36 p.m., signed with clinical nurse supervisor (CNS)-C's name, followed by "nurse" - entry on March 12, 2024, at 3:11 p.m., signed with LPN-G's name, followed by "nurse" - entry on March 13, 2024, at 3:58 p.m., signed with CNS-C's name, followed by "nurse" - entry on March 14, 2024, at 8:44 a.m., signed with CNS-C's name, followed by "nurse" - entry on March 14, 2024, at 1:45 p.m., signed with LPN-G's name, followed by "nurse" - entry on March 18, 2024, at 7:56 a.m., signed with LPN-G's name, followed by "nurse" - entry on March 18, 2024, at 9:23 a.m., signed with LPN-G's name, followed by "nurse" - entry on March 18, 2024, at 9:32 a.m., signed with LPN-G's name, followed by "nurse" - entry on March 19, 2024, at 11:07 a.m., signed with LPN-G's name, followed by "nurse" - entry on March 19, 2024, at 12:54 p.m., signed with LPN-G's name, followed by "nurse" - entry on March 22, 2024, at 12:28 p.m., signed with LPN-G's name, followed by "nurse" - entry on March 25, 2024, at 10:19 a.m., signed with LPN-G's name, followed by "nurse" - entry on March 25, 2024, at 12:25 p.m., signed with LPN-G's name, followed by "nurse" - entry on April 2, 2024, at 2:20 p.m., signed with LPN-G's name, followed by "nurse" - entry on April 5, 2024, at 12:09 p.m., signed with LPN-G's name, followed by "nurse" - entry on April 24, 2024, at 8:20 a.m., signed with	0 690		

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0 690	Continued From page 19 LPN-G's name, followed by "nurse" - entry on May 10, 2024, at 2:49 p.m., signed with LPN-G's name, followed by "nurse" - entry on May 21, 2024, at 3:37 p.m., signed with LPN-G's name, followed by "nurse" - entry on July 3, 2024, at 1:31 p.m., signed with LPN-G's name, followed by "nurse" - entry on July 9, 2024, at 12:28 p.m., signed with LPN-G's name, followed by "nurse" - entry on August 16, 2024, at 12:15 p.m., signed with LPN-G's name, followed by "nurse." R1's record lacked entries authenticated with the name and title of the person making the entry. R3 R3's diagnoses included Huntington's disease. R3's Assisted Living SP, dated June 10, 2024, indicated R3 received services including assistance with dressing, grooming, bathing, eating, walking, housekeeping, laundry, shopping, meal prep, assistance with making appointments, socialization, transportation, medication administration or assistance with self-administration, medication monitoring and related tasks, orientation management, anxiety management, assistance with substance abuse, and assistance with depression/withdrawal. R3's Progress Notes, dated July 22, 2024, through August 15, 2024, printed September 17, 2024, included the following: - entry on July 22, 2024, at 10:54 a.m., signed with LPN-G's name, followed by "nurse" - entry on August 15, 2024, at 11:11 a.m., signed with CNS-C's name, followed by "nurse." R3's record lacked entries authenticated with the name and title of the person making the entry.	0 690		

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0 690	Continued From page 20 During an interview on September 18, 2024, at 10:45 a.m., CNS-C stated the electronic medical record software applied her and LPN-G's signature and title of "nurse" when they made an entry. CNS-C stated she would be working with the software provider to change this to ensure signatures were authenticated with their appropriate title. The licensee's Resident Records policy, reviewed January 3, 2022, indicated record entries would be legible, permanently recorded, dated, and signed by the person making the entry. The policy lacked direction that entries must be authenticated with the title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require	0 730		

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0 730	Continued From page 21 documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of a smoking assessment for one of one resident (R1.)	0 730		

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0 730	Continued From page 22 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 diagnoses included traumatic brain injury, type 2 diabetes, cardiomyopathy (disease of the heart muscle), and West Nile encephalitis (inflammation of the brain caused by mosquito bite). R1's Service Plan, dated June 3, 2024, indicated R1 required assistance with rooming, bathing, medication administration, orientation management, anxiety management, withdrawal/isolation, socialization, money management, meals, shopping, assistance making appointments, transportation, housekeeping, and laundry. R1's Master Assessment, dated July 15, 2024, indicated R1 was a "Current Active Smoker," and was "Independent." The assessment lacked an assessment of the ability to smoke without causing burns or injury to the resident or others or damage to property, as required. On September 18, 2024, at 11:06 a.m., clinical nurse supervisor (CNS)-C stated she does a smoking assessment, and stated she and the resident talk about their smoking, make sure they are safe doing so, and the storage of lighter etc. CNS-C stated the assessment piece was done	0 730		

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0 730	Continued From page 23 but stated the assessment was not in the resident's records. CNS-C said she would need to talk to the electronic medical record provider used to add the smoking component into the assessment. CNS-C stated some assessments were separate, but she could not find "a smoking assessment" in resident's record. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated January 3, 2022, noted a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs would be completed. A comprehensive assessment included but may not be limited to the requirements outlined by Minnesota rules, to include: -smoking including the ability to smoke without causing burns or injury to the resident or others or damage to property. No further information provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 24 Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 September 17, 2024, from 10:05 a.m. to 11:30 a.m., the surveyor toured the facility with maintenance staff (M)-D. The following was observed. The dining room fan had a thick layer of dust and grease. M-D stated they had just cleaned the fan in the past year when they painted the facility. Bedroom 2 was missing a lever on one of the casement-style window hardware. Bedroom 4 was missing the knobs for the window cranks which made the hardware difficult to use. The bathroom across from the medication room had water damage around the exhaust fan. The toilet seat and grab bars were not secured.	0 800		

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	20396	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWERMENT HEALTHCARE	112007 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
0 800	Continued From page 25 On September 17, 2024, at 11:30 a.m., M-D stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical facility elements did not constitute a distinct hazard to life. The licensee had door lock hardware on the egress side of the patio door leading outside. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 820		

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0 820	Continued From page 26 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 September 17, 2024, from 10:05 a.m. to 11:30 a.m., the surveyor toured the facility with maintenance staff (M)-D. The patio door had a hotel-style door guard security latch at the top of the door. The patio door had been identified on the evacuation plans as an emergency exit and also had an emergency exit sign posted above the door. Required exit doors in this type of facility are allowed to be provided with one security type lock (2 locking devices total) such as the deadbolt, in addition to the door latch lock, and installed not more than 48 inches from the floor. On September 17, 2024, M-D stated they understood the exit doors could not have extra locks in addition to a standard latch and deadbolt with a thumb turn. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.	0 900		

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0 900	Continued From page 27 (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. This had the potential to affect all current 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	0 900		

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0 900	Continued From page 28 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 September 18, 2024, at 10:46 a.m., owner (O)-A stated an unsigned copy of the licensee's contract had not been sent to the Ombudsman as required. O-A stated, "We didn't do that." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=F	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 an employee 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:	01290		

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01290	Continued From page 29 Based on interview and record review, the licensee failed to ensure background studies were affiliated with the assisted living facility license for one of two employees (registered nurse (RN)-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 potential to affect a large portion or all of the residents). The findings include: RN-E began employment on January 2, 2024, to provide direct care services and supervision under the licensee's assisted living license. RN-E obtained her RN license on December 13, 2002. Upon review of the NETStudy 2.0 website, on September 16, 2024, at 1:47 p.m., RN-E was not listed on the employee roster for this licensee. On September 16, 2024, at 1:50 p.m., licensed assisted living director in residency (LALDR)-B stated the licensee had an intern working for them that "separated" RN-E from the employee roster through NETStudy 2.0, in error, and they had not "fixed" it. LALDR-B provided an employee roster for a separate licensee operated by the same franchise, dated September 16, 2024, that included RN-E and determined RN-E to be "eligible," and affiliated on December 5, 2022. The licensee's Background Checks policy, reviewed January 3, 2022, indicated the licensee	01290		

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01290	Continued From page 30 would conduct a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors; however, the policy did not indicate the background study must be affiliated with the assisted living license. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees	01560		

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01560	Continued From page 31 trained, the frequency of training, and the basic topics covered. 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 September 17, 2024, at 10:07 a.m., via email, owner (O)-A indicated the licensee did not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form to provide to consumers. The licensee's Assisted Living Dementia Training policy, reviewed January 3, 2022, lacked direction to provide a written or electronic description of the dementia training program to consumers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=F	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	01620		

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01620	Continued From page 32 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident 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 assessments with the uniform assessment tool that included all required content for three of three residents (R1, R3, R4). 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:	01620		

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01620	Continued From page 33 During the entrance conference on September 16, 2024, at 11:15 a.m., owner (O)-A stated the licensee was familiar with current minimum assisted living requirements. R1 R1's diagnoses included traumatic brain injury, type 2 diabetes, cardiomyopathy (disease of the heart muscle), and West Nile encephalitis (inflammation of the brain caused by mosquito bite). R1's Assisted Living Service Plan (SP), dated June 3, 2024, indicated R1 required assistance with rooming, bathing, medication administration, orientation management, anxiety management, withdrawal/isolation, socialization, money management, meals, shopping, assistance making appointments, transportation, housekeeping, and laundry. On September 17, 2024, at 7:45 a.m., the surveyor observed while unlicensed personnel (ULP)-F administered R1's oral medications. R1's record included a Master Assessment, dated July 15, 2024, identified as a 90 day assessment. R3 R3's diagnoses included Huntington's disease. R3's Assisted Living SP, dated June 10, 2024, indicated R3 received services including assistance with dressing, grooming, bathing, eating, walking, housekeeping, laundry, shopping, meal prep, assistance with making appointments, socialization, transportation, medication administration or assistance with self-administration, medication monitoring and	01620		

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01620	Continued From page 34 related tasks, orientation management, anxiety management, assistance with substance abuse, and assistance with depression/withdrawal. R3's record included a Master Assessment, dated September 9, 2024, identified as a 90 day assessment. R4 R4's diagnoses included major depressive disorder, social phobia, and severe social anxiety. R4's Assisted Living SP, dated August 23, 2024, indicated R4 received services including assistance with grooming, bathing, medication administration or assistance with self administration, verbal or visual medication reminders, medication monitoring, management of repetitive behavior, agitation management, anxiety management, housekeeping, laundry, shopping, meal prep, assistance making appointments, arranging transportation, money management, and socialization. R4's record included a Master Assessment, dated July 3, 2024, identified as a 90 day assessment. On September 18, 2024, at 11:09 a.m., the assessment tool used by the licensee was reviewed with clinical nurse supervisor (CNS)-C. On September 18, 2024, at 11:12 a.m., CNS-C stated the assessment tool used by the licensee did not include sleep schedule, spiritual and cultural preferences, risk for dehydration, history of UTI (urinary tract infection), current fluid intake, weight and smoking to include "the ability to smoke without causing burns or injury to the resident or others or damage to property," as required.	01620		

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01620	Continued From page 35 The licensee's Initial and On-Going Nursing Assessment of Residents policy, reviewed January 3, 2023, noted a comprehensive assessment included but may not be limited to the requirements outlined by Minnesota rules. The comprehensive assessment would include sleep schedule, spiritual and cultural preferences, risk for dehydration, history of UTI, current fluid intake, weight and smoking to include "the ability to smoke without causing burns or injury to the resident or others or damage to property." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01650	Continued From page 36	01650		
01650 SS=E	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan included the required content for two of three residents (R3, R4). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 37 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: R3 R3's diagnoses included Huntington's disease. R3's Assisted Living Service Plan (SP), dated June 10, 2024, indicated R3 received services including assistance with dressing, grooming, bathing, eating, walking, housekeeping, laundry, shopping, meal prep, assistance with making appointments, socialization, transportation, medication administration or assistance with self-administration, medication monitoring and related tasks, orientation management, anxiety management, assistance with substance abuse, and assistance with depression/withdrawal. R3's Assisted Living SP lacked the following required content: - the frequency of each service, according to the resident's current assessment and preferences. R4 R4's diagnoses included major depressive disorder, social phobia, and severe social anxiety. R4's Assisted Living SP, dated August 23, 2024, indicated R4 received services including assistance with grooming, bathing, medication administration or assistance with self	01650		

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01650	Continued From page 38 administration, verbal or visual medication reminders, medication monitoring, management of repetitive behavior, agitation management, anxiety management, housekeeping, laundry, shopping, meal prep, assistance making appointments, arranging transportation, money management, and socialization. R4's Assisted Living SP lacked the following required content: - the frequency of each service, according to the resident's current assessment and preferences. On September 18, 2024, at 10:51 a.m., clinical nurse supervisor (CNS)-C stated some of the services listed on the service plan were services that the resident "may" need help with occasionally, for example, assistance with bathing or dressing. CNS-C stated the service plan should note that by including "as needed" for the frequency, rather than leaving the frequency blank. The licensee's Contents of Service Plans policy, dated January 3, 2022, indicated all residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse and would include the frequency of each service according to resident assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services	01690		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWERMENT HEALTHCARE	112007 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
01690	Continued From page 39 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN).	01690		

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01690	Continued From page 40 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: During the entrance conference on September 16, 2024, at 11:11 a.m., clinical nurse supervisor (CNS)-C stated the facility provided medication management services to the licensee's residents. The licensee's provided policies lacked: - requesting and receiving prescriptions for medications - resolving medication errors. On September 18, 2024, at 1:16 p.m., via email, owner (O)-A indicated he had provided all of the medication policies the licensee used, and noted the licensee did not have this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have	01700		

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01700	Continued From page 41 a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for one of one resident (R1). 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	01700		

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01700	Continued From page 42 of the residents). The findings include: During the entrance conference on September 16, 2024, at 11:27 a.m., licensed practical nurse (LPN)-G stated the licensee provided medication management services to the licensee's residents. R1's diagnoses included traumatic brain injury, type 2 diabetes, cardiomyopathy (disease of the heart muscle), and West Nile encephalitis (inflammation of the brain caused by mosquito bite). R1's Service Plan, dated June 3, 2024, indicated R1 required assistance with rooming, bathing, medication administration, orientation management, anxiety management, withdrawal/isolation, socialization, money management, meals, shopping, assistance making appointments, transportation, housekeeping, and laundry. On September 17, 2024, at 7:45 a.m., with R1's permission, the surveyor observed as unlicensed personnel (ULP)-F prepared and administered R1's oral medications. R1's Medication Sheet, dated August 2024, included the following medications: -atorvastatin (treats high cholesterol) 20 milligrams (mg) by mouth (po) daily; -lisinopril (treat high blood pressure) 20 mg po daily; -spironolactone (treat high blood pressure) 25 mg, one-half tablet (12.5 mg) po daily; -tamsulosin (treats urinary frequency) 0.4 mg, two capsules (0.8 mg) po daily 30 minutes after meal; -venlafaxine (treats anxiety) 150 mg po daily;	01700		

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01700	Continued From page 43 -acetaminophen (mild pain reliever) 325 mg, two tablets po every 4 hours as needed; -Desitin ointment (treat rash) apply to affected areas several times daily as needed; and -gavilax (treats constipation) mix 17 grams with full glass of water daily as needed. R1's most current prescriber orders, dated January 24, 2023, which was 238 days past the annual renewal date requirement, included the above medications, with the following discrepancies: -clotrimazole (antifungal cream) 1% apply to rash armpits and chest twice daily (not on medication sheet); -clotrimazole 1-005% apply to skin twice daily until gone (not on medication sheet); -metformin (treats high blood sugar levels) 500 mg one tablet daily with biggest meal of the day (listed twice on orders, not on medication sheet); and -tamsulosin 0.4 mg one tablet daily after meal (administering two tablets daily on medication sheet). R1's Medication Assessment Form, dated June 13, 2024, indicated R1 was not capable of setting up or tracking medication administration times, could not coordinate refills from providers and pharmacies, and was not a candidate to self-administer his medications, therefore, received medication administration by facility staff. R1's medication assessment included review of medications R1 was taking, indications, common side effects, and risk of medication diversion. R1's record lacked evidence the RN had conducted a medication assessment to include: - contraindications; and	01700		

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01700	Continued From page 44 - allergic or adverse reactions, and actions to address these issues. On September 18, 2024, at 10:45 a.m., R1's medication assessment was reviewed with clinical nurse supervisor (CNS)-C and she stated the assessment did not include allergies or contradictions of medications. CNS-C stated she had never included those items on the medication assessment. On September 18, 2024, at 1:48 p.m., CNS-C stated the medication assessment form would need to be changed to include allergies and medication contraindications. The licensee's Storage of Medications policy, dated January 3, 2022, indicated a registered nurse must conduct a face-to-face nursing assessment of a resident's need for medication management services, and based on the assessment, the RN would develop an individualized medication management plan. The policy lacked direction to include the required content in the medication assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or	01780		

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01780	Continued From page 45 unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. 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: During the entrance conference on September 16, 2024, at 11:11 a.m., clinical nurse supervisor (CNS)-C stated the facility provided medication management services to the licensee's residents. The licensee's Delegation of Medications To Be Given To Residents By Unlicensed Staff for Residents Time Away From Home policy, reviewed January 3, 2024, lacked the following required content:	01780		

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01780	Continued From page 46 - for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse (RN); and - for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days. On September 18, 2024, at 1:16 p.m., via email, owner (O)-A indicated he had provided all of the medication policies the licensee used. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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01790	Continued From page 47 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790		

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01790	Continued From page 48 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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: During the entrance conference on September 16, 2024, at 11:11 a.m., clinical nurse supervisor (CNS)-C stated the facility provided medication management services to the licensee's residents. The licensee's Delegation of Medications To Be Given To Residents By Unlicensed Staff for Residents Time Away From Home policy, reviewed January 3, 2024, noted the written procedures for the ULP providing medications for residents having unplanned time away when the licensed nurse was not available. The policy lacked the following required content: - a review by the RN of the completion of the task to verify it was completed accurately by the ULP.	01790		

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01790	Continued From page 49 On September 18, 2024, at 1:16 p.m., via email, owner (O)-A indicated he had provided all of the medication policies the licensee used. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to renew prescriptions at least every 12 months for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included traumatic brain injury, type 2 diabetes, cardiomyopathy (disease of the heart muscle), and West Nile encephalitis	01830		

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01830	Continued From page 50 (inflammation of the brain caused by mosquito bite). R1's Service Plan, dated June 3, 2024, indicated R1 required assistance with rooming, bathing, medication administration, orientation management, anxiety management, withdrawal/isolation, socialization, money management, meals, shopping, assistance making appointments, transportation, housekeeping, and laundry. R1's Medication Assessment Form, dated June 13, 2024, indicated R1 received medication administration by facility staff. On September 17, 2024, at 7:45 a.m., with R1's permission, the surveyor observed as unlicensed personnel (ULP)-F prepared and administered R1's oral medications. R1's Medication Sheet, dated August 2024, included the following medications: -atorvastatin (treats high cholesterol) 20 milligrams (mg) by mouth (po) daily; -lisinopril (treat high blood pressure) 20 mg po daily; -spironolactone (treat high blood pressure) 25 mg, one-half tablet (12.5 mg) po daily; -tamsulosin (treats urinary frequency) 0.4 mg, two capsules (0.8 mg) po daily 30 minutes after meal; -venlafaxine (treats anxiety) 150 mg po daily; -acetaminophen (mild pain reliever) 325 mg, two tablets po every 4 hours as needed; -Desitin ointment (treat rash) apply to affected areas several times daily as needed; and -gavilax (treats constipation) mix 17 grams with full glass of water daily as needed. R1's most current prescriber orders, dated	01830		

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01830	Continued From page 51 January 24, 2023, which was 238 days past the annual renewal date requirement, included the above medications, with the following discrepancies: -clotrimazole (antifungal cream) 1% apply to rash armpits and chest twice daily (not on medication sheet); -clotrimazole 1-005% apply to skin twice daily until gone (not on medication sheet); -metformin (treats high blood sugar levels) 500 mg one tablet daily with biggest meal of the day (listed twice on orders, not on medication sheet); and -tamsulosin 0.4 mg one tablet daily after meal (administering two tablets daily on medication sheet). On September 18, 2024, at 10:06 a.m., clinical nurse supervisor (CNS)-C stated R1's prescriber orders were his admission orders and had not been updated at least annually, as required. The licensee lacked a policy including requesting and receiving prescriptions for medications, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 52 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted only authorized personnel access for one of one medication storage rooms. 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). Findings include: The licensee had one medication storage room, that held two medication carts. One medication cart was labeled "Rosewood" for this licensee, and one medication cart was labeled "Lakewood" for the attached facility, separated by a door. The two medication carts stored medications for three residents living in this licensee and three residents living in the attached facility. On September 17, 2024, at 6:30 a.m., unlicensed personnel (ULP)-I stated she worked the night shift and "covers [works in]" the two attached facilities during her shift, and stated the door between the two was "always open." At 6:40 a.m., ULP-I was observed in the laundry room of the attached facility. The medication storage room door was observed to be open. On September 17, 2024, at 6:45 a.m., ULP-I stated, "I was just getting meds [medications]	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20396	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWERMENT HEALTHCARE	112007 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
01880	Continued From page 53 ready," and stated she needed to walk to the other facility to get something. ULP-I stated she could not see the medication storage room from the attached facility laundry room. The surveyor observed as ULP-I prepared medications for R4, and shut the door as she left the medication room. On September 17, 2024, at 7:16 a.m., the surveyor observed ULP-F assisting an unidentified resident. The surveyor observed ULP-F leave the medication room with the medication room door open and walk down the hallway. The surveyor walked into the medication room and observed both medication carts were unlocked. On September 17, 2024, at 7:18 a.m., ULP-F returned to the medication room and when asked about the medication room door being left unattended and open with both medication carts unlocked, ULP-F stated "ok, the door was opened, but you were in here." ULP-F stated she never leaves the medication door unlocked with both carts unlocked. On September 17, 2024, at 9:55 a.m., clinical nurse supervisor (CNS)-C stated leaving the medication room door unlocked was a "huge no." CNS-C said whoever was giving medication needed to remain in the medication room or the door needed to be locked. CNS-C added the licensee was fortunate because they had locked medication carts and a door but added the door and medication carts needed to be locked when not in use. CNS-C said, the person with the medication key was responsible and stated she did not care who it was, no one should be left in the medication room with the medication carts unlocked but the person who had the key.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20396	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWERMENT HEALTHCARE	112007 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
01880	Continued From page 54 The licensee's Storage of Medications policy dated January 3, 2022, noted medications would be handled and stored per acceptable standards. The register nurse (RN) would provide education including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. When secured storage of the medication was necessary the RN would identify where the medications would be stored, how they would be secured or locked under proper temperature controls and who had access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all three current residents in the assisted living facility, staff, and any visitors of	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20396	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWERMENT HEALTHCARE	112007 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
03090	Continued From page 55 the licensee. This practice resulted in a level one violation (a violation that has not 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: Upon entrance on September 16, 2024, at 11:00 a.m., the surveyor observed outside the front entrance and just inside the front entrance of the assisted living facility. There was no required posting for notification of electronic monitoring devices. On September 16, 2024, at 1:47 p.m., licensed assisted living director in residency (LALDR)-B stated she was aware of the requirement to post notification of electronic monitoring devices and stated the notification was posted, but someone must have taken it down. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *09/16/24*
Time: 12:51:44
Report: 7994241164

Food and Beverage Establishment Inspection Report

Location:

Empowerment Healthcare
112007 Hidden Creek Place
Chaska, MN55318
Carver County, 10

Establishment Info:

ID #: 0037526
Risk:
Announced Inspection: No

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.

4-500 Equipment Maintenance and Operation

4-501.110 ***** Priority 2 *****

MN Rule 4626.0785 Provide the proper wash water temperature for the warewashing machine as specified in rule and the manufacturer's data plate.

CURRENTLY FACILITY IS NOT KEEPING RECORDS OF THE DISHWASHER TESTING. FACILITY WILL TEST DISHWASHER AND EMAIL PICTURES TO INSPECTOR.

Comply By: 09/16/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ONE CFPM IS REQUIRED FOR EVERY 2 FACILITIES. CURRENTLY THERE IS JUST ONE FOR ALL 4 HOUSES AT THE MOMENT.

Comply By: 09/16/24

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE. FLOOR IS LAMINATE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION

AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A
RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241164 of 09/16/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed:_____
Establishment Representative

Signed: Crystal Elva

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us