



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

May 2, 2024

Licensee

Empire Systems Home Care

6012 York Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL34526015

Dear Licensee:

On April 17, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 29, 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,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor

State Evaluation Team

Email: [casey.devries@state.mn.us](mailto:casey.devries@state.mn.us)

Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 000}                                                      | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL36554015-1</p> <p>On April 17, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 29, 2024. At the time of the survey, there were three residents, all of whom received services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.</p> | {0 000}                                                                                      | <p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p> |  |                                                   |
| {0 250}<br>SS=F                                              | <p>144G.20 Subdivision 1 Conditions</p> <p>(a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {0 250}                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 250}                                                      | Continued From page 1<br><br>result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:<br>(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;<br>(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;<br>(3) performs any act detrimental to the health, safety, and welfare of a resident;<br>(4) obtains the license by fraud or misrepresentation;<br>(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;<br>(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;<br>(7) interferes with or impedes a representative of the department in contacting the facility's residents;<br>(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;<br>(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;<br>(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;<br>(11) refuses to initiate a background study under | {0 250}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 250}                                                      | Continued From page 2<br><br>section 144.057 or 245A.04;<br>(12) fails to timely pay any fines assessed by the commissioner;<br>(13) violates any local, city, or township ordinance relating to housing or assisted living services;<br>(14) has repeated incidents of personnel performing services beyond their competency level; or<br>(15) has operated beyond the scope of the assisted living facility's license category.<br>(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                  | {0 250}                                                                                      |                                                                                                                          |  |                                                   |
| {0 320}<br>SS=F                                              | 144G.30 Subdivision 1 Regulatory powers<br><br>(a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter.<br>(b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, | {0 320}                                                                                      |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 320}                                                      | Continued From page 3<br><br>subdivision 12.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | {0 320}                                                         |                                                                                                                          |                          |                                                   |
| {0 470}<br>SS=F                                              | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for<br>determining its staffing level that:<br>(i) includes an evaluation, to be conducted at<br>least twice a year, of the appropriateness of<br>staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet<br>the scheduled and reasonably foreseeable<br>unscheduled needs of each resident as required<br>by the residents' assessments and service plans<br>on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly<br>and effectively to individual resident emergencies<br>and to emergency, life safety, and disaster<br>situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are<br>available 24 hours per day, seven days per week,<br>who are responsible for responding to the<br>requests of residents for assistance with health or<br>safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached<br>building, or on a contiguous campus with the<br>facility in order to respond within a reasonable<br>amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the<br>appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced<br>by: | {0 470}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 470}                                                             | Continued From page 4<br><br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 470}                                                                                              |                                                                                                                          |  |                                                                    |
| {0 480}<br>SS=F                                                     | <b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b><br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {0 480}                                                                                              |                                                                                                                          |  |                                                                    |
| {0 485}<br>SS=C                                                     | <b>144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements</b><br><br>(13) offer to provide or make available at least the following services to residents:<br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br>(A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and<br>(C) the facility cannot require a resident to include and pay for meals in their contract;<br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br><br>This MN Requirement is not met as evidenced | {0 485}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 485}                                                      | Continued From page 5<br><br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | {0 485}                                                                                      |                                                                                                                          |  |                                                   |
| {0 510}<br>SS=F                                              | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 510}                                                                                      |                                                                                                                          |  |                                                   |
| {0 650}<br>SS=F                                              | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of                                                                           | {0 650}                                                                                      |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 650}                                                             | Continued From page 6<br><br>staff persons providing supervision;<br>(4) documentation of annual performance<br>reviews that identify areas of improvement<br>needed and training needs;<br>(5) for individuals providing assisted living<br>services, verification that required health<br>screenings under subdivision 9 have taken place<br>and the dates of those screenings; and<br>(6) documentation of the background study as<br>required under section 144.057.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                      | {0 650}                                                                                              |                                                                                                                          |  |                                                                    |
| {0 660}<br>SS=F                                                     | <b>144G.42 Subd. 9 Tuberculosis prevention and<br/>control</b><br><br>(a) The facility must establish and maintain a<br>comprehensive tuberculosis infection control<br>program according to the most current<br>tuberculosis infection control guidelines issued by<br>the United States Centers for Disease Control<br>and Prevention (CDC), Division of Tuberculosis<br>Elimination, as published in the CDC's Morbidity<br>and Mortality Weekly Report. The program must<br>include a tuberculosis infection control plan that<br>covers all paid and unpaid employees,<br>contractors, students, and regularly scheduled<br>volunteers. The commissioner shall provide<br>technical assistance regarding implementation of<br>the guidelines.<br>(b) The facility must maintain written evidence of<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required. | {0 660}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 680}                                                      | Continued From page 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | {0 680}                                                                                      |                                                                                                                          |                          |                                                   |
| {0 680}<br>SS=F                                              | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 680}                                                                                      |                                                                                                                          |                          |                                                   |
| {0 730}<br>SS=F                                              | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {0 730}                                                                                      |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 730}                                                             | Continued From page 8<br><br>number;<br>(2) the name, address, and telephone number of<br>the resident's emergency contact, legal<br>representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of<br>the resident's health and medical service<br>providers, if known;<br>(4) health information, including medical history,<br>allergies, and when the provider is managing<br>medications, treatments or therapies that require<br>documentation, and other relevant health<br>records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives,<br>guardianships, powers of attorney, or<br>conservatorships;<br>(7) the facility's current and previous<br>assessments and service plans;<br>(8) all records of communications pertinent to the<br>resident's services;<br>(9) documentation of significant changes in the<br>resident's status and actions taken in response to<br>the needs of the resident, including reporting to<br>the appropriate supervisor or health care<br>professional;<br>(10) documentation of incidents involving the<br>resident and actions taken in response to the<br>needs of the resident, including reporting to the<br>appropriate supervisor or health care<br>professional;<br>(11) documentation that services have been<br>provided as identified in the service plan;<br>(12) documentation that the resident has received<br>and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and<br>any resolution;<br>(14) a discharge summary, including service<br>termination notice and related documentation,<br>when applicable; and | {0 730}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 730}                                                      | Continued From page 9<br><br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | {0 730}                                                                                      |                                                                                                                          |  |                                                   |
| {0 780}<br>SS=F                                              | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by: | {0 780}                                                                                      |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 780}                                                             | Continued From page 10<br><br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 780}                                                                                              |                                                                                                                          |  |                                                                    |
| {0 800}<br>SS=F                                                     | <b>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</b><br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                            | {0 800}                                                                                              |                                                                                                                          |  |                                                                    |
| {0 810}<br>SS=F                                                     | <b>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</b><br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. | {0 810}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 810}                                                      | Continued From page 11<br><br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 810}                                                         |                                                                                                                          |                          |                                                   |
| {01370}<br>SS=D                                              | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and                                                                     | {01370}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01370}                                                             | Continued From page 12<br><br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {01370}                                                                                              |                                                                                                                          |  |                                                                    |
| {01380}<br>SS=D                                                     | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {01380}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {01380}                                                      | Continued From page 13<br><br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {01380}                                                                                      |                                                                                                                          |  |                                                   |
| {01440}<br>SS=D                                              | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. | {01440}                                                                                      |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01440}                                                             | Continued From page 14                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {01440}                                                                                              |                                                                                                                          |  |                                                                    |
| {01470}<br>SS=F                                                     | <p>This MN Requirement is not met as evidenced by:<br/>No further action required.</p> <p><b>144G.63 Subd. 2 Content of required orientation</b></p> <p>(a) The orientation must contain the following topics:</p> <p>(1) an overview of this chapter;</p> <p>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;</p> <p>(3) handling of emergencies and use of emergency services;</p> <p>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);</p> <p>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</p> <p>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</p> <p>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</p> <p>(9) a review of the types of assisted living services the employee will be providing and the</p> | {01470}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01470}                                                             | Continued From page 15<br><br>facility's category of licensure.<br>(b) In addition to the topics in paragraph (a),<br>orientation may also contain training on providing<br>services to residents with hearing loss. Any<br>training on hearing loss provided under this<br>subdivision must be high quality and research<br>based, may include online training, and must<br>include training on one or more of the following<br>topics:<br>(1) an explanation of age-related hearing loss<br>and how it manifests itself, its prevalence, and<br>the challenges it poses to communication;<br>(2) health impacts related to untreated<br>age-related hearing loss, such as increased<br>incidence of dementia, falls, hospitalizations,<br>isolation, and depression; or<br>(3) information about strategies and technology<br>that may enhance communication and<br>involvement, including communication strategies,<br>assistive listening devices, hearing aids, visual<br>and tactile alerting devices, communication<br>access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required. | {01470}                                                                                              |                                                                                                                          |  |                                                                    |
| {01500}<br>SS=D                                                     | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must<br>complete at least eight hours of annual training<br>for each 12 months of employment. The training<br>may be obtained from the facility or another<br>source and must include topics relevant to the<br>provision of assisted living services. The annual<br>training must include:<br>(1) training on reporting of maltreatment of<br>vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | {01500}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {01500}                                                      | Continued From page 16<br><br>staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or | {01500}                                                                                      |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01500}                                                             | Continued From page 17<br><br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {01500}                                                                                              |                                                                                                                          |  |                                                                    |
| {01530}<br>SS=F                                                     | <b>144G.64 TRAINING IN DEMENTIA CARE<br/>REQUIRED</b><br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.<br>Direct-care employees must have at least two hours of training on topics related to dementia for | {01530}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>04/17/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {01530}                                                      | Continued From page 18<br><br>each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {01530}                                                         |                                                                                                                          |                          |                                                   |
| {01620}<br>SS=F                                              | 144G.70 Subd. 2 (c-e) Initial reviews,<br>assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must<br>be conducted no more than 14 calendar days<br>after initiation of services. Ongoing resident<br>reassessment and monitoring must be conducted<br>as needed based on changes in the needs of the<br>resident and cannot exceed 90 calendar days<br>from the last date of the assessment.<br>(d) For residents only receiving assisted living<br>services specified in section 144G.08, subdivision<br>9, clauses (1) to (5), the facility shall complete an<br>individualized initial review of the resident's needs<br>and preferences. The initial review must be<br>completed within 30 calendar days of the start of<br>services. Resident monitoring and review must<br>be conducted as needed based on changes in<br>the needs of the resident and cannot exceed 90<br>calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident<br>of the availability of and contact information for<br>long-term care consultation services under<br>section 256B.0911, prior to the date on which a<br>prospective resident executes a contract with a<br>facility or the date on which a prospective<br>resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required. | {01620}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01760}                                                             | Continued From page 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | {01760}                                                                                              |                                                                                                                          |  |                                                                    |
| {01760}<br>SS=F                                                     | <b>144G.71 Subd. 8 Documentation of<br/>administration of medication</b><br><br>Each medication administered by the assisted<br>living facility staff must be documented in the<br>resident's record. The documentation must<br>include the signature and title of the person who<br>administered the medication. The documentation<br>must include the medication name, dosage, date<br>and time administered, and method and route of<br>administration. The staff must document the<br>reason why medication administration was not<br>completed as prescribed and document any<br>follow-up procedures that were provided to meet<br>the resident's needs when medication was not<br>administered as prescribed and in compliance<br>with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required. | {01760}                                                                                              |                                                                                                                          |  |                                                                    |
| {01890}<br>SS=F                                                     | <b>144G.71 Subd. 20 Prescription drugs</b><br><br>A prescription drug, prior to being set up for<br>immediate or later administration, must be kept in<br>the original container in which it was dispensed<br>by the pharmacy bearing the original prescription<br>label with legible information including the<br>expiration or beyond-use date of a time-dated<br>drug.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                | {01890}                                                                                              |                                                                                                                          |  |                                                                    |
| {02400}<br>SS=C                                                     | <b>144G.91 Subd. 12 Visitors and social<br/>participation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {02400}                                                                                              |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/17/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {02400}                                                             | <p>Continued From page 20</p> <p>(a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan.</p> <p>(b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents.</p> <p>This MN Requirement is not met as evidenced by:<br/>No further action required.</p> | {02400}                                                                                              |                                                                                                                          |  |                                                                    |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

March 27, 2024

Licensee

Empire Systems Home Care

6012 York Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL34526015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 29, 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 . . ."

### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or



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

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

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00**

**St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

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

#### **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this



section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

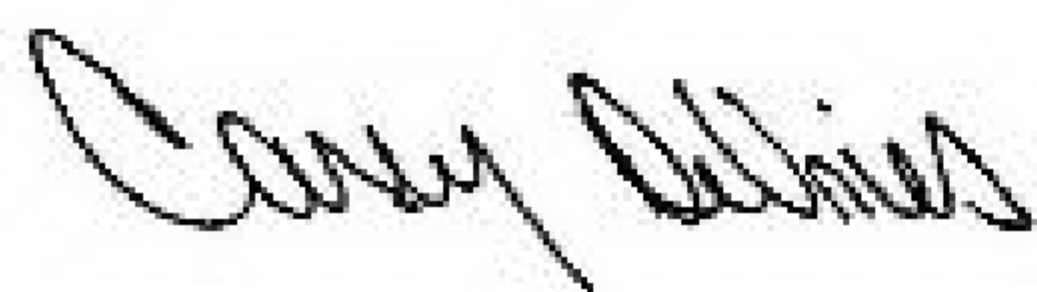
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto: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,



Casey DeVries, Supervisor

State Evaluation Team

Email: [casey.devries@state.mn.us](mailto:casey.devries@state.mn.us)

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                              |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 000                                                        | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL34526015-0</p> <p>On February 26, 2024, through February 29,<br/>2024, the Minnesota Department of Health<br/>conducted a full survey at the above provider, and<br/>the following correction orders are issued. At the<br/>time of the survey, there were two residents, both<br/>of whom received services under the Assisted<br/>Living license.</p> <p>An immediate correction order was identified on<br/>February 28, 2024, issued for SL34526015-0, tag<br/>identification 1290.</p> <p>On February 29, 2024, the immediacy of<br/>correction order 1290 was removed, however<br/>non-compliance remained, and the scope and<br/>level remained unchanged.</p> | 0 000                                                                                        | <p>Minnesota Department of Health is<br/>documenting the State Correction Orders<br/>using federal software. Tag numbers have<br/>been assigned to Minnesota State<br/>Statutes for Assisted Living License<br/>Providers. The assigned tag number<br/>appears in the far-left column entitled "ID<br/>Prefix Tag." The state Statute number and<br/>the corresponding text of the state Statute<br/>out of compliance is listed in the<br/>"Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the surveyors'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>The letter in the left column is used for<br/>tracking purposes and reflects the scope<br/>and level issued pursuant to 144G.31<br/>subd. 1, 2, and 3.</p> |  |                                              |
| 0 250<br>SS=F                                                | <p>144G.20 Subdivision 1 Conditions</p> <p>(a) The commissioner may refuse to grant a</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0 250                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                              |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 250                                                               | <p>Continued From page 1</p> <p>provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:</p> <p>(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;</p> <p>(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;</p> <p>(3) performs any act detrimental to the health, safety, and welfare of a resident;</p> <p>(4) obtains the license by fraud or misrepresentation;</p> <p>(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;</p> <p>(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;</p> <p>(7) interferes with or impedes a representative of the department in contacting the facility's residents;</p> <p>(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;</p> <p>(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;</p> <p>(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;</p> | 0 250                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 250                                                               | <p>Continued From page 2</p> <p>(11) refuses to initiate a background study under section 144.057 or 245A.04;</p> <p>(12) fails to timely pay any fines assessed by the commissioner;</p> <p>(13) violates any local, city, or township ordinance relating to housing or assisted living services;</p> <p>(14) has repeated incidents of personnel performing services beyond their competency level; or</p> <p>(15) has operated beyond the scope of the assisted living facility's license category.</p> <p>(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on February 26,</p> | 0 250                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 250                                                        | <p>Continued From page 3</p> <p>2024, at 10:00 a.m., housing manager/unlicensed personnel (HM/ULP)-A and clinical nurse supervisor (CNS)- C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services.</p> <p>The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:</p> <ul style="list-style-type: none"><li>- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.</li><li>- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.</li><li>- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.</li><li>- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.</li><li>- Reporting of Maltreatment of Vulnerable Adults.</li><li>- Electronic Monitoring in Certain Facilities.</li><li>- I understand pursuant to Minn. Stat. sect. 13.04</li></ul> | 0 250                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 250                                                        | <p>Continued From page 4</p> <p>Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.</p> <p>- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.</p> <p>- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.</p> | 0 250                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 250                                                               | <p>Continued From page 5</p> <p>- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.</p> <p>- I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.</p> <p>Page five was electronically signed by Authorized Agent Administrator (A)-B on May 31, 2023.</p> <p>The licensee had an Assisted Living license issued on July 1, 2023, with an expiration date of June 30, 2024.</p> <p>The licensee failed to ensure the following policies and procedures were developed and/or implemented:</p> <ul style="list-style-type: none"><li>-to provide a completed employee roster;</li><li>-to develop and implement staffing plan;</li><li>- food was prepared and served according to the Minnesota Food Code;</li><li>- to have a menu prepared at least one week in advance and made available to all residents;</li><li>- to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control;</li><li>-employee records management, and background studies;</li><li>- to maintain a tuberculosis (TB) prevention and control program;</li></ul> | 0 250                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 250                                                               | <p>Continued From page 6</p> <p>-emergency preparedness;<br/>- medication management and administration;<br/>- resident record included documentation of all services provided and medications administered;<br/>-fire protection and physical environment;<br/>-staff orientation, supervision, annual training, competency training and evaluation;<br/>- conducting initial assessment on 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, and resident reassessment no more than 14 calendar days after initiation of services and ongoing resident reassessment and monitoring not exceed 90 calendar days from the last date of the assessment.</p> <p>As a result of this survey, the following orders were issued 0250, 0320, 0470, 0480, 0485, 0510, 0650, 0660, 0680, 0730, 0780, 0800, 0810, 1290, 1370, 1380, 1440, 1470, 1500, 1530, 1620, 1760, 1890, 2400, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 250                                                                                                |                                                                                                                          |  |                                                        |
| 0 320<br>SS=F                                                       | <p><b>144G.30 Subdivision 1 Regulatory powers</b></p> <p>(a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 320                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 320                                                               | <p>Continued From page 7</p> <p>(b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to provide a completed employee roster to determine compliance with licensure laws and rules.</p> <p>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).</p> <p>The findings include:</p> <p>On February 27-28, 2024, the surveyor observed clinical nurse supervisor (CNS)-C performing nursing duties which included interacting with residents and gathering documentation for the survey team.</p> <p>On February 26, 2024, at 12:11 p.m., registered</p> | 0 320                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 320                                                               | <p>Continued From page 8</p> <p>nurse (RN)-D stated they worked as a backup nurse when the primary nurse was unable to perform their duties.</p> <p>On February 26, 2024, at 8:01 a.m., the surveyor emailed administrator (A)-B and licensed assisted living director (LALD)-H the survey introduction letter informing the licensee of the survey and requested an employee roster to include full names, titles, and hire dates.</p> <p>On February 26, 2024, at 10:53 a.m., the surveyor emailed A-B and LALD-H requesting an employee roster.</p> <p>On February 26, 2024, at 12:41 p.m., the surveyor emailed A-B requesting an employee roster.</p> <p>On February 26, 2024, at 1:07 p.m., the surveyor received an email from A-B which included a staff roster entitled Empire Systems Home Care. The list lacked information regarding licensed staff members to include LALD-H, CNS-C, RN-D and owner/licensed practical nurse (O/LPN)-F.</p> <p>On February 28, 2024, at 9:30 a.m., while on-site at the facility, the surveyor requested a completed employee roster from house manager/unlicensed personnel (HM/ULP)-A.</p> <p>On February 28, 2024, at 1:45 p.m., while on-site at the facility, the surveyor requested a completed employee roster from O/LPN-F, LALD-H, A-B, and HM/ULP-A.</p> <p>On February 29, 2024, at 10:08 a.m., the surveyor emailed A-B and LALD-H requesting a completed employee roster.</p> | 0 320                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 320                                                        | Continued From page 9<br><br>On February 29, 2024, at 1:59 p.m., the surveyor sent the licensee the survey exit email which concluded the licensee's routine survey.<br><br>On February 29, 2024, at 2:08 p.m., the surveyor received an email from A-B which included a second staff roster entitled Empire Systems Home Care. The list still lacked full names, titles, and hire dates for CNS-C and RN-D.<br><br>On March 6, 2024, at 9:48 a.m., the surveyor emailed A-D and requested a date of hire for CNS-C. The surveyor did not receive a response.<br><br>On March 7, 2024, at 7:29 a.m., the surveyor sent a text message to CNS-C to see if they knew their date of hire. CNS-C's text response indicated they were hired by the licensee somewhere around January 10, 2024, and further indicated, "I don't work for them anymore."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 320                                                                                        |                                                                                                                          |  |                                              |
| 0 470<br>SS=F                                                | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(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<br>(iii) ensures that the facility can respond promptly                                                                                                                                                                                                                                                                                                                                                                                 | 0 470                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                               | <p>Continued From page 10</p> <p>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:</p> <p>(i) awake;</p> <p>(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;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. In addition, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required. This had the potential to affect all residents, staff, and visitors.</p> <p>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</p> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                               | <p>Continued From page 11</p> <p>a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee held an assisted living license. The facility was licensed for a capacity of six residents and had a current census of two residents.</p> <p><b>STAFFING PLAN</b><br/>On February 27, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-C stated they did not do a staffing plan, and housing manger/unlicensed personnel (HM/ULP)-A was responsible for staffing.</p> <p>On February 27, 2024, at 12:52 p.m., HM/ULP-A stated the staffing plan was developed by the licensed assisted living director ((LALD)-H) and the owner/licensed practical nurse ((O/LPN)-F).</p> <p>On February 29, 2024, at 12:25 p.m., the surveyor inquired if the licensee developed and implemented a staffing plan and evaluated the plan twice per year. O/LPN-F stated the staffing plan was developed and evaluated by LALD-H, CNS-C, and HM/ULP-A. O/LPN-F stated they did not know why CNS-C stated they were not involved in developing the staffing plan.</p> <p>On February 29, 2024, at 11:13 a.m., via email correspondence, the surveyor received an undated Staffing Management and Contingency Staffing Plan. The staffing plan lacked the following:</p> <ul style="list-style-type: none"><li>-evidence the licensee considered the resident's needs and level of acuity, staff experience, and competency, etc., as metrics to determine their staffing levels;</li><li>-lacked evidence to show the plan was revised twice per year; and</li></ul> | 0 470                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 470                                                        | Continued From page 12<br><br>-updated with the name of the current CNS.<br><br>POSTING<br>On February 26, 2024, at 11:16 a.m., during facility tour, the surveyor observed a staff schedule posted on the main level by the punch time clock machine dated January 28, 2023, through February 10, 2023.<br><br>On February 26, 2024, at 11:16 a.m., HM/ULP-A stated the posted staffing schedule was not current because they were creating a new staffing schedule for the new period.<br><br>Although requested, the licensee did not provide a staffing policy.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 470                                                           |                                                                                                                          |  |                                              |
| 0 480<br>SS=F                                                | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a                                                                                                                           | 0 480                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 480                                                               | Continued From page 13<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 27, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates                                                                                              | 0 480                                                                                                |                                                                                                                          |  |                                                     |
| 0 485<br>SS=C                                                       | 144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br>(A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and<br>(C) the facility cannot require a resident to include | 0 485                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 485                                                        | <p>Continued From page 14</p> <p>and pay for meals in their contract;<br/>(ii) weekly housekeeping;<br/>(iii) weekly laundry service;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all of the residents of the facility.</p> <p>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).</p> <p>The findings include:</p> <p>On February 26, 2024, at 11:16 a.m., during facility tour, the surveyor observed there was no menu posted.</p> <p>On February 26, 2024, at 12:50 p.m., the surveyor inquired if the licensee had a menu. Housing manger/unlicensed personnel (HM/ULP)-A stated they were working on a new menu. Surveyor inquired to see last week's menu and HM/ULP-A stated they did not have it. R2 who was sitting at the dining table along with HM/ULP-A and R1 eating Chipotle for lunch stated the licensee did not have menu, "[they] just started doing it about a week ago, they do not have it". R2 stated they had been eating prepackaged meals from a company called "Factor" and before that they ate frozen food out</p> | 0 485                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 485                                                        | <p>Continued From page 15</p> <p>of the freezer. R2 also stated they (the licensee) just started cooking about a week or two ago.</p> <p>On February 26, 2024, at approximately 1:20 p.m., HM/ULP-A provided surveyor with undated document entitled Direction for Breakfast, Lunch, Dinner, &amp; Snacks and stated it was a menu guide. The menu guide read,<br/>"DIRECTIONS FOR BREAKFAST, LUNCH, DINNER, &amp; SNACKS<br/>No one is allowed to remove any food from this Refrigerator to Cook for themselves! This is an Assisted Living which means you Assist by Cooking yourself. Residents may use the Microwave. If you bring your lunch, take it home do not leave it. All Nightshift Employees clean out the Refrigerator and Throw anything leftover away...</p> <p>Breakfast:</p> <p>1. Ask Resident if they want, If they want, then you Fix for them, we do hold Food until Someone wants, we Cook Fresh. ALTERNATIVE TO MEAL IS PEANUT BUTTER OR CHEESE SANDWICH.</p> <p>Lunch:</p> <p>2. First Ask Resident if they want. If they do, then prepare food for them. We do hold Food in fridge until resident wants. We Cook/prepare food Fresh. ALTERNATIVE TO MEAL IS PEANUT BUTTER OR CHEESE SANDWICH.</p> <p>Dinner:</p> <p>3. First Ask Resident if they want. If they do, then prepare food for them. We do hold Food in fridge until resident wants. We Cook/prepare food Fresh. ALTERNATIVE TO MEAL IS PEANUT BUTTER OR CHEESE SANDWICH."</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p> | 0 485                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 485                                                               | Continued From page 16<br><br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 0 485                                                                                                |                                                                                                                          |  |                                                        |
| 0 510<br>SS=F                                                       | <b>144G.41 Subd. 3 Infection control program</b><br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors.<br><br>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).<br><br>The findings include: | 0 510                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 510                                                        | <p>Continued From page 17</p> <p>The facility was a rambler style home which included a main floor and a basement.</p> <p>On February 26, 2024, at 9:50 a.m., the surveyor observed the facility's basement bathroom which lacked soap and hand towels for drying.</p> <p>On February 26, 2024, at 1:10 p.m., the surveyor observed the facility's basement bathroom which lacked soap and hand towels for drying.</p> <p>On February 27, 2024, at 11:36 a.m., the surveyor observed the facility's basement bathroom which lacked soap and hand towels for drying.</p> <p>On February 27, 2024, at 11:42 a.m., clinical nurse supervisor (CNS)-C stated R2 and R3 used to fight over soap products in the basement bathroom and would hoard them in their rooms but did not have an explanation as to why hand towels for drying were unavailable. CNS-C stated they should have kept the bathrooms stocked with soap and hand towels for drying.</p> <p>On February 27, 2024, at 1:45 p.m., the surveyor observed a hand soap dispenser was placed in the basement bathroom but still lacked hand towels for drying.</p> <p>On February 27, 2024, at 1:53 p.m., R2 stated they had requested soap and hand towels for drying for a long time. They stated they had their own soap which they kept in their room since the licensee was not providing any.</p> <p>The Center for Disease Control (CDC) FAQ hand hygiene guidance, last revised November 4, 2022, indicated, "always washing your hands</p> | 0 510                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                               | <p>Continued From page 18</p> <p>after you use the toilet, whether it is in your home or somewhere else. Germs in feces (poop) can make you sick. These germs can get on your hands after you use the toilet or change a diaper. If you don't wash them off, you can pass them from person to person and make people sick. Make a habit of washing your hands after you use the toilet every time to reduce your chance of getting sick and spreading germs."</p> <p>The licensee's Standard Precautions For All Health Care Workers policy, undated and referenced Minnesota (MN) Statutes: 144A.472, Sub.1 (14), indicated:</p> <p>"1. Assume that blood and all body fluids, with or without visible blood, from all clients are potentially infectious.<br/>2. WASH HANDS"</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p> | 0 510                                                                                                |                                                                                                                          |  |                                                        |
| 0 650<br>SS=F                                                       | <p>144G.42 Subd. 8 Employee records</p> <p>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including</p>                                                                                                                                                                                                                                              | 0 650                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 650                                                               | <p>Continued From page 19</p> <p>qualifications, responsibilities, and identification of staff persons providing supervision;<br/>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br/>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br/>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure annual performance reviews were completed and a current job description was included in employee records for two of three employees (HM/ULP-A, MM/ULP-G).</p> <p>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).</p> <p>The findings include:</p> <p>HM/ULP-A<br/>HM/ULP-A was hired on May 20, 2018, to provide direct cares to residents and manage the licensee.</p> <p>On February 26, 27, and 28, 2024, the surveyor observed HM/ULP-A providing cares, providing</p> | 0 650                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 650                                                               | <p>Continued From page 20</p> <p>requested documents and managing the licensee throughout the survey.</p> <p>HM/ULP-A's employee record lacked documentation of the following:<br/>-current job description; and<br/>-annual performance reviews.</p> <p>MM/ULP-G<br/>MM/ULP-G was hired on June 7, 2020, to work in marketing and provide direct cares to residents.</p> <p>MM/ULP-G's employee record lacked documentation of the following:<br/>-current job description; and<br/>-annual performance reviews.</p> <p>On February 28, 2024, at 9:45 a.m., owner/licensed practical nurse (O/LPN)-F stated annual performance reviews for HM/ULP-A were not completed. They stated they must have been overlooked.</p> <p>On February 29, 2024, at 10:42 a.m., HM/ULP-A stated they were unable to locate the above requested documentation for themselves or MM/ULP-G.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 650                                                                                                |                                                                                                                          |  |                                                        |
| 0 660<br>SS=F                                                       | <p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 660                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                               | <p>Continued From page 21</p> <p>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.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment.</p> <p>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).</p> <p>The findings include:</p> <p>On February 26, 2024, at 12:09 p.m., via email correspondences, licensee provided the surveyor with a Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH updated June 2021,</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 660                                                        | Continued From page 22<br><br>which was completed on October 22, 2022, for the licensee's sister facility. The licensee lacked an updated TB risk assessment tailored to the licensee's facility.<br><br>On February 29, 2024, at 12:45 p.m., licensed assisted living director (LALD)-H stated they look at the TB risk assessment worksheet on a quarterly bases but did not revise it, as there was no change to be made to the worksheet.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                | 0 660                                                                                        |                                                                                                                          |  |                                              |
| 0 680<br>SS=F                                                | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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 | 0 680                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 680                                                        | <p>Continued From page 23</p> <p>received emergency and disaster training are allowed to work only when trained staff are also working on site.<br/>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. The licensee also failed to post the plan in prominent area.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's undated, Emergency Preparedness Plan in Assisted Living lacked evidence of the following required content:</p> <ul style="list-style-type: none"><li>- EPP reviewed and updated annually;</li><li>- quarterly review of missing resident;</li><li>- policies and procedures including evacuation;</li><li>- policies and procedure for volunteers;</li><li>- development of communication plan;</li><li>- names and contact information;</li><li>- sharing information on occupancy and needs;</li><li>- emergency prep training program;</li><li>- long term care family notifications;</li></ul> | 0 680                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                               | <p>Continued From page 24</p> <ul style="list-style-type: none"><li>- roles under a wavier declared by secretary;</li><li>- emergency officials contact information; and</li><li>- emergency preparedness testing requirements.</li></ul> <p><b>POSTING</b><br/>On February 26, 2024, at 12:50p.m. surveyor observed the EPP document was not posted in prominent area. House manager/unlicensed personnel (HM/ULP)-A stated the EPP document was located at the licensee's office in another location.</p> <p>On February 29, 2024, at 12:45 p.m., licensed assisted living director (LALD)-H stated the licensee reviewed the EPP annually, but they were not aware they needed documentation to show the review was done. LALD-H also stated they were not aware the EPP document had to be posted in a prominent area. Administrator (A)-B stated documents are not updated with current employee names as the EPP plan is a big document, and the nurse turnover is high, "nurses come and go like changing your clothes".</p> <p>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff during periods of an emergency or disaster that disrupts services.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.</p> <p>No further information was provided.</p> | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 680                                                        | Continued From page 25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 680                                                                                        |                                                                                                                          |  |                                              |
|                                                              | TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                                                                                                                          |  |                                              |
| 0 730<br>SS=F                                                | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the<br>following for each resident:<br>(1) identifying information, including the resident's<br>name, date of birth, address, and telephone<br>number;<br>(2) the name, address, and telephone number of<br>the resident's emergency contact, legal<br>representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of<br>the resident's health and medical service<br>providers, if known;<br>(4) health information, including medical history,<br>allergies, and when the provider is managing<br>medications, treatments or therapies that require<br>documentation, and other relevant health<br>records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives,<br>guardianships, powers of attorney, or<br>conservatorships;<br>(7) the facility's current and previous<br>assessments and service plans;<br>(8) all records of communications pertinent to the<br>resident's services;<br>(9) documentation of significant changes in the<br>resident's status and actions taken in response to<br>the needs of the resident, including reporting to<br>the appropriate supervisor or health care<br>professional;<br>(10) documentation of incidents involving the<br>resident and actions taken in response to the<br>needs of the resident, including reporting to the<br>appropriate supervisor or health care<br>professional; | 0 730                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 730                                                               | <p>Continued From page 26</p> <p>(11) documentation that services have been provided as identified in the service plan;<br/>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br/>(13) documentation of complaints received and any resolution;<br/>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br/>(15) other documentation required under this chapter and relevant to the resident's services or status.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure the resident record included documentation of all services provided for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with medication administration, bathing, dressing, grooming, housekeeping, laundry, meals assistant, behavior management, and safety checks.</p> <p>R1's Service Recap Summary form January 1, 2024, through January 31, 2024, lacked the</p> | 0 730                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 730                                                               | <b>Continued From page 27</b><br><br>following documentation for services provided during multiple shifts:<br>-116 of 124 scheduled services for activity assistance;<br>-15 of 31 scheduled services for bathing assistance;<br>-26 of 31 scheduled services for bathing reminders;<br>-27 of 31 scheduled services for deep room cleaning;<br>-26 of 31 scheduled services for grooming;<br>-27 of 31 scheduled services for incontinence care;<br>-27 of 31 scheduled services for behaviors - agitation;<br>-27 of 31 scheduled services for behaviors - anxiety;<br>-27 of 31 scheduled services for behaviors - hoarding;<br>-27 of 31 scheduled services for behaviors - physical aggression;<br>-27 of 31 scheduled services for behaviors - repetitive behavior;<br>-27 of 31 scheduled services for behaviors - resistive tendencies;<br>-28 of 62 scheduled services for behaviors - verbal aggression;<br>-27 of 31 scheduled services for behaviors - self injury;<br>-28 of 62 scheduled services for symptoms- depression;<br>-142 of 186 scheduled services for meal reminder;<br>-57 of 62 scheduled services for toileting;<br>-27 of 31 scheduled services for respiratory equipment care;<br>-54 of 68 scheduled services for skin care;<br>-28 of 31 scheduled services for remove garbage;<br>-2 of 5 scheduled services for record - blood pressure; | 0 730                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 |                                                                                                                          |                          |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                              |
| 0 730                                                        | <p>Continued From page 28</p> <p>-2 of 4 scheduled services for record - oxygen saturation;<br/>-2 of 4 scheduled services for record -temperature;<br/>-30 of 23 scheduled services for -symptom screen;<br/>-70 of 87 scheduled services for safety checks; and<br/>-97 of 217 scheduled services for medication administration.</p> <p>On February 27, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)- C stated they are aware there are some gaps in medication and service administration charting for all residents and stated they just started with the company, and they will work on fixing the problems.</p> <p>The licensee's undated Clinical Documentation policy read, "1. Skilled nursing/therapy care rendered shall be documented on the Nursing/Therapy Note form or electronically on RTask or similar third party software platform.<br/>2. A separate note shall be completed for each visit/shift including the date and time service provided, and signed by the appropriate professional.<br/>3. Additional information that is pertinent to the client's care or condition may be documented on the Progress Note or Flow Sheet, which can be done manually or via electronic documentation software (RTask)."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 730                                                           |                                                                                                                          |                          |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 780                                                               | Continued From page 29                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0 780                                                                                                |                                                                                                                          |  |                                                     |
| 0 780<br>SS=F                                                       | <p><b>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</b></p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>    (i) provide smoke alarms in each room used for sleeping purposes;</p> <p>    (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>    (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>    (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and</p> <p>    (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p> | 0 780                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 780                                                               | <p>Continued From page 30</p> <p>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).</p> <p>Findings include:</p> <p>On February 27, 2024, at 12:00 p.m., survey staff toured the facility with administrator (A)-B. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected.</p> <p>These deficient conditions were visually verified by A-B accompanying on the tour.</p> <p>During interview on February 27, 2024, at 1:30 p.m. A-B stated they understood the smoke alarm requirements.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 780                                                                                                |                                                                                                                          |  |                                                        |
| 0 800<br>SS=F                                                       | <p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 800                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 800                                                               | <p>Continued From page 31</p> <p>This MN Requirement is not met as evidenced by:<br/>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.</p> <p>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).</p> <p>Findings include:</p> <p>On February 27, 2024, at 12:00 p.m., survey staff toured the facility with administrator (A)-B. It was observed that the window well in bedroom #5 had multiple, large pieces of plastic from a broken snow shield in it. The window well also had approximately six inches of dead leaves piled in it. The leaves made it difficult to operate the egress window. Window wells must be cleaned out and well maintained to allow for the proper function of the egress window.</p> <p>It was observed that the flooring transitions between the living room, bedroom #5, and the bathroom were missing leaving the subfloor exposed to damage. The flooring materials were not secured to the subfloor causing a potential</p> | 0 800                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                               | <p>Continued From page 32</p> <p>tripping hazard for any resident leaving the living area to use the bathroom or enter bedroom #5.</p> <p>It was observed that the upstairs bathroom had tile damage by the toilet on the floor and along the wall base. The wall showed signs of water damage and parts of the wall structure were exposed to the wet environment of the bathroom. Rust and dark staining were present at the corner where the wall had been damaged.</p> <p>It was observed that the windows in upstairs bedroom #2 did not fully function. The left window pane would operate correctly, but the right window pane would not open. A-B attempted to open both windows using the hardware present, but could not get two of the windows to open. All windows should be maintained so they function as they were designed to.</p> <p>It was observed that the egress window in upstairs bedroom #2 was in the bathroom behind a door with a lock. Survey staff explained to A-B that the lock in the path of egress that required a tool would cause a delay in the proper exiting of the space during a fire or similar emergency. If the bathroom window is to function as the egress window, the path of egress cannot be obstructed by a door that locks. A-B stated they would replace the locking hardware with a door knob that did not have a lock.</p> <p>It was observed that the exterior siding at the front of the house had two holes in it. The holes were sized large enough to allow rodents and other pests into the structure. There was damage visible to the building sheathing which could allow pests into the wall cavity.</p> <p>During interview on February 27, 2024, at 1:30</p> | 0 800                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 800                                                               | Continued From page 33<br><br>p.m. A-B stated they understood the above-listed deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 0 800                                                                  |                                                                                                                          |  |                                                     |
| 0 810<br>SS=F                                                       | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 810                                                        | <p>Continued From page 34</p> <p>activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On February 29, 2024, administrator (A)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN<br/>The licensee FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following:</p> <p>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine,</p> | 0 810                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                               | <p>Continued From page 35</p> <p>and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step.</p> <p>The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.</p> <p>The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.</p> <p>During an interview on February 29, 2024, at 12:30 p.m., A-B stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.</p> <p><b>TRAINING</b><br/>Record review indicated the licensee failed to provide evacuation training to residents at least once per year. A-B was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan.</p> <p>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. A-B was unable to provide documentation showing any training completed or training scheduled for a future date for employees on the fire safety and evacuation</p> | 0 810                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                               | Continued From page 36<br><br>plan.<br><br>During an interview on February 29, 2024, at 12:30 p.m., A-B stated they understood the areas of their training that were insufficient and would work on bringing them into compliance.<br><br>DRILLS<br>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evidenced by the fire drill reports provided. An evacuation drill was conducted on 11/15/23. No other documentation was provided.<br><br>During an interview on February 29, 2024, at 12:30 p.m., A-B stated there were no further documented drills for the facility and verified this deficient condition.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810                                                                                                |                                                                                                                          |  |                                                        |
| 01290<br>SS=I                                                       | 144G.60 Subdivision 1 Background studies required<br><br>(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.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of an employee in good faith reliance on information or records obtained under                                                                                                                                                             | 01290                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                               | <p>Continued From page 37</p> <p>this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for four of nine employees (clinical nurse supervisor (CNS-C), (unlicensed personnel (ULP-E, ULP-G), and house manager/unlicensed personnel (HM/ULP-A).</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>CNS-C<br/>CNS-C was hired on January10, 2024, to provide nursing cares to residents and to supervise ULPs.</p> <p>On February 28, 2024, the Minnesota Board of Nursing website indicated CNS-C's nursing license was effective September 9, 2014.</p> <p>On February 27 and 28, 2024, the surveyor observed CNS-C perform their supervisory role with the licensee.</p> <p>The licensee's staffing schedule for February 1,</p> | 01290                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01290                                                        | <p>Continued From page 38</p> <p>2024, through March 9, 2024, indicated CNS-C was on-call for all shifts. The licensee's NETstudy2.0 roster indicated CNS-C's BGS was initiated on February 27, 2024, affiliated to the licensee's health facility identification number (HFID) 34526 during the survey. The NETstudy2.0 roster indicated the BGS was currently "in process".</p> <p>ULP- E<br/>ULP- E was hired on February 6, 2022, to provide direct cares and services to residents.</p> <p>The licensee's staffing schedule for February 1, 2024, through March 9, 2024, indicated ULP-E was scheduled to work the day shifts, 7:00 a.m. to 3:00 p.m., for the following dates: February 26, 27, 29 and the evening shift, 3:00 p.m. to 11:00 p.m., for the following dates: February 29, and March 1, 2, 7, 8, 9, 2024.</p> <p>The licensee's NETstudy2.0 indicated ULP-E's BGS was affiliated to the licensee's sister facility HFID 32957. The "Eligible covid 19 study" status for the BGS was expired on December 31, 2022. The licensee lacked evidence the licensee submitted a new BGS for ULP-E after the covid 19 eligible status had expired and affiliated to HFID 34526.</p> <p>ULP-G<br/>ULP-G was hired on July 7, 2020, as a marketing manager and a backup care provider to provide direct cares and services to residents.</p> <p>The licensee's staffing schedule for February 1, 2024, through March 9, 2024, indicated ULP-G was not scheduled to work any day. A-B stated all of their managers, including ULP-G, were back up care givers and would fill open shifts if</p> | 01290                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01290                                                        | <p>Continued From page 39</p> <p>needed.</p> <p>The licensee's NETstudy2.0 roster indicated ULP-G's background study was affiliated to the licensee's sister facility HFID 32957. The "Eligible covid 19 study" status for the BGS expired on December 31, 2022. The licensee lacked evidence the licensee submitted a BGS for ULP-G after the covid 19 eligible status expired and affiliated to HFID 34526.</p> <p>HM/ULP-A<br/>HM/ULP-A was hired on May 20, 2018, to perform managerial duties and to provide direct cares and services to residents.</p> <p>On February 27, 2024, at approximately 8:15 a.m., the surveyor observed HM/ULP-A administer medication to R1. They were also observed performing managerial duties on February 26, 27, and 28, 2024.</p> <p>The licensee's staffing schedule for February 1, 2024, through March 9, 2024, indicated HM/ULP-A was scheduled to work the day shift, 7:00 a.m. to 3:00 p.m., on the following dates: February 1, 3, 4, 5, 8, 15, 16, 17, 18 ,19, 22, 26, 27, and 28, 2024. They were also scheduled for the evening shift, 3:00 p.m. to 11:00 p.m., for the following dates: February 7, 13, 14, 21, and March 1 through 7, 2024.</p> <p>HM/ULP-A's employee record included a letter from the Department of Human Services which indicated the employee is clear to work under a sister facility's HFID 32957. The licensee lacked evidence HM/ULP-A was affiliated to the licensee's HFID 34526 and was not included on the NETstudy 2.0 roster provided.</p> | 01290                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01290                                                               | <p>Continued From page 40</p> <p>On February 28, 2024, at 9:25 a.m., A-D stated they did not know the "eligible covid 19 study" status was expired and they did not know they had to resubmit a BGS. They also stated the human resource person started the BGS process for CNS-C but did not follow through with completing it. A-D stated HM/ULP-A, ULP-E, and ULP-G currently worked unsupervised. A-D stated they were running all of their BGS under their sister facility HFID 32957 and then getting them affiliated to all of their other facilities HFIDs. A-D stated HM/ULP-A's BGS was never affiliated with the current licensee's HFID but was aware of the requirement.</p> <p>The licensee's Employment Process policy under Background Checks indicated BGS study will be completed on all employees and employees may not work with residents until background study has been received.</p> <p>The Minnesota Department of Human Services (DHS) website for Emergency Background Studies End dated as updated September 28, 2023, indicated, "Expiration dates for emergency studies are displayed as 12/31/2022 in NETStudy 2.0" and "The Background Studies Division no longer reviews new records or information for an individual who only has an emergency study in NETStudy 2.0."</p> <p>The DHS website for Background Studies dated as updated December 28, 2023, indicated, "DHS temporarily modified background studies during the COVID-19 pandemic. Those modifications ended Jan. 1, 2023. Learn more about the return to fully compliant studies."</p> <p>No further information was provided.</p> | 01290                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01290                                                        | Continued From page 41<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE<br><br>On February 29, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 01290                                                                                        |                                                                                                                          |  |                                              |
| 01370<br>SS=D                                                | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, | 01370                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01370                                                               | <p>Continued From page 42</p> <p>cultural background, and family;<br/>(12) awareness of confidentiality and privacy;<br/>(13) understanding appropriate boundaries<br/>between staff and residents and the resident's<br/>family;<br/>(14) procedures to use in handling various<br/>emergency situations; and<br/>(15) awareness of commonly used health<br/>technology equipment and assistive devices.</p> <p>This MN Requirement is not met as evidenced<br/>by:<br/>Based on interview and record review, the<br/>licensee failed to ensure training and competency<br/>evaluations were completed for all required skill<br/>areas, prior to providing services, for one of two<br/>unlicensed personnel (marketing<br/>manager/unlicensed personnel (MM/ULP)-G).</p> <p>This practice resulted in a level two violation (a<br/>violation that did not harm a resident's health or<br/>safety but had the potential to have harmed a<br/>resident's health or safety) and was issued at an<br/>isolated scope (when one or a limited number of<br/>residents are affected or one or a limited number<br/>of staff are involved, or the situation has occurred<br/>only occasionally).</p> <p>The findings include:</p> <p>MM/ULP-G was hired on June 7, 2020, to work in<br/>marketing and provide direct cares to residents.</p> <p>MM/ULP-G's employee record included an<br/>Educare (online training platform) transcript which<br/>indicated MM/ULP-G completed their orientations<br/>and competency trainings on May 19-23, 2023.</p> <p>MM/ULP-G's employee record lacked the<br/>following competency training and evaluation:</p> | 01370                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01370                                                        | <p>Continued From page 43</p> <p>-reports of changes in the resident's condition to the supervisor designated by the facility;<br/>-maintenance of a clean and safe environment;<br/>-standby assistance techniques and how to perform them;<br/>-preparation of modified diets as ordered by a licensed health professional;<br/>-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and<br/>-awareness of commonly used health technology equipment and assistive devices.</p> <p>On February 28, 2024, at 10:20 a.m., owner/licensed practical nurse (O/LPN)-F stated MM/ULP-G was their marketing manager but was also trained last year to work as a ULP. O/LPN-F and administrator (A)-B both stated MM/ULP-G had worked multiple shifts on multiple occasions and was expected to step in and help, when necessary, with resident cares. O/LPN-F stated the only training completed by MM/ULP-G was completed in Educare.</p> <p>On February 29, 2024, at 10:42 a.m., house manager/ULP (HM/ULP)-A stated they were unable to locate additional competency training documentation for MM/ULP-G.</p> <p>On February 29, 2024, at 11:29 a.m., clinical nurse supervisor (CNS)-C stated they were not the CNS when MM/ULP-G would have completed their competency training as they were hired only a few months ago. CNS-C stated they were aware of competency training requirements for ULPs.</p> <p>No further information was provided.</p> | 01370                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                          |                          |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                              |
| 01370                                                        | Continued From page 44                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 01370                                                           |                                                                                                                          |                          |                                              |
|                                                              | TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                          |                          |                                              |
| 01380<br>SS=D                                                | 144G.61 Subd. 2 (b) Training and evaluation of<br>unlicensed personn<br><br>(b) In addition to paragraph (a), training and<br>competency evaluation for unlicensed personnel<br>providing assisted living services must include:<br>(1) observing, reporting, and documenting<br>resident status;<br>(2) basic knowledge of body functioning and<br>changes in body functioning, injuries, or other<br>observed changes that must be reported to<br>appropriate personnel;<br>(3) reading and recording temperature, pulse,<br>and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive,<br>and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as<br>required.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on interview and record review, the<br>licensee failed to ensure training and competency<br>evaluations were completed for all required skill<br>areas, prior to providing services, for one of two<br>unlicensed personnel (marketing<br>manager/unlicensed personnel (MM/ULP)-G).<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety) and was issued at an<br>isolated scope (when one or a limited number of<br>residents are affected or one or a limited number | 01380                                                           |                                                                                                                          |                          |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01380                                                               | <p>Continued From page 45</p> <p>of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>MM/ULP-G was hired on June 7, 2020, to work in marketing and provide direct cares to residents.</p> <p>MM/ULP-G's employee record included an Educare (online training platform) transcript which indicated MM/ULP-G completed their orientations and competency trainings on May 19-23, 2023.</p> <p>MM/ULP-G's employee record lacked the following competency training and evaluation:<br/>-basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and<br/>-recognizing physical, emotional, cognitive, and developmental needs of the resident.</p> <p>On February 28, 2024, at 10:20 a.m., owner/licensed practical nurse (O/LPN)-F stated MM/ULP-G was their marketing manager but was also trained last year to work as a ULP. O/LPN-F and administrator (A)-B both stated MM/ULP-G had worked multiple shifts on multiple occasions and was expected to step in and help, when necessary, with resident cares. O/LPN-F stated the only training completed by MM/ULP-G was completed in Educare.</p> <p>On February 29, 2024, at 10:42 a.m., house manager/ULP (HM/ULP)-A stated they were unable to locate additional competency training documentation for MM/ULP-G.</p> <p>On February 29, 2024, at 11:29 a.m., clinical nurse supervisor (CNS)-C stated they were not</p> | 01380                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01380                                                               | Continued From page 46<br><br>the CNS when MM/ULP-G would have completed their competency training as they were hired only a few months ago. CNS-C stated they were aware of competency training requirements for ULPs.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 01380                                                                  |                                                                                                                          |  |                                                     |
| 01440<br>SS=D                                                       | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced | 01440                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01440                                                        | <p>Continued From page 47</p> <p>by:<br/>Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (marketing manager/unlicensed personnel (MM/ULP)-G).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>MM/ULP-G was hired on June 7, 2020, to work in marketing and provide direct cares to residents.</p> <p>MM/ULP-G's employee record included an Educare (online training platform) transcript which indicated MM/ULP-G completed their orientation and some competency training on May 19 through 23, 2023.</p> <p>MM/ULP-G's employee record lacked evidence a RN supervision was conducted within 30 days of providing services.</p> <p>On February 28, 2024, at 10:20 a.m., owner/licensed practical nurse (O/LPN)-F stated MM/ULP-G was their marketing manager but was also trained last year to work as a ULP. O/LPN-F and administrator (A)-B both stated MM/ULP-G had worked multiple shifts on multiple occasions and was expected to step in and help, when necessary, with resident cares.</p> | 01440                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01440                                                               | Continued From page 48<br><br>On February 29, 2024, at 10:42 a.m., house manager/ULP (HM/ULP)-A stated they were unable to locate documentation for a completed RN 30-day supervision for MM/ULP-G.<br><br>On February 29, 2024, at 11:29 a.m., clinical nurse supervisor (CNS)-C stated RN supervisions for ULPs were required every three months. CNS-C stated they were newly hired in the past few months and was unsure if the previous nurse was completing RN 30-day supervisions. CNS-C stated they were working on making sure trainings and RN 30-day supervisions were up to date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01440                                                                  |                                                                                                                          |  |                                                     |
| 01470<br>SS=F                                                       | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;                 | 01470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                               | <p>Continued From page 49</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</p> <p>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</p> <p>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</p> <p>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.</p> <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;</p> <p>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> | 01470                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01470                                                               | <p>Continued From page 50</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation before providing services for three of four supervising and direct care employees (registered nurse (RN)-D, clinical nurse supervisor (CNS)-C, house manager/unlicensed personnel (HM/ULP)-A).</p> <p>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).</p> <p>The findings include:</p> <p>CNS-C<br/>The licensee did not provide CNS-C's date of hire after multiple requests. On March 7, 2024, at 7:29 a.m., CNS-C's text message indicated they were hired somewhere around January 10, 2024.</p> <p>On February 27-28, 2024, the surveyor observed CNS-C performing nursing duties which included interacting with residents and gathering documentation for the survey team.</p> <p>CNS-C's employee record included a staff orientation form and an Educare (online training platform) transcript.</p> <p>CNS-C's employee record lacked orientation for the following topics at the time of hire:<br/>-overview of assisted living statutes; and<br/>-principles of person-centered planning/service</p> | 01470                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01470                                                               | <p>Continued From page 51</p> <p>delivery.</p> <p>RN-D<br/>RN-D was hired on June 5, 2023, to provide direct cares to residents and oversite to ULPs.</p> <p>RN-D's employee record included a Staff Orientation Outline &amp; Sign-Off form and Educare transcript.</p> <p>RN-D's Staff Orientation Outline &amp; Sign-Off form and Educare transcript both lacked orientation for the following topics at the time of hire:<br/>-principles of person-centered planning/service delivery.</p> <p>HM/ULP-A<br/>HM/ULP-A was hired on May 20, 2018, to provide direct cares to residents and manage the licensee.</p> <p>On February 26, 27 and 28, 2024, the surveyor observed HM/ULP-A providing cares and managing the licensee throughout the survey.</p> <p>HM/ULP-A's employee record included an Educare transcript which indicated HM/ULP-A last completed an overview of assisted living statutes in the Guide to Assisted Living training module on December 23, 2020. New assisted living statutes were put into place on August 1, 2021, and HM/ULP-A would have required training on the new assisted living statutes on or before August 1, 2021.</p> <p>On February 26, 2024, at 12:11 p.m., RN-D stated they had been employed with the licensee since the summer of 2023 and were the on-call nurse in the event the current clinical nurse supervisor (CNS) was unable to perform their</p> | 01470                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                               | <p>Continued From page 52</p> <p>duties.</p> <p>On February 28, 2024, at 9:45 a.m., owner/licensed practical nurse (O/LPN)-F stated they did not think orientations were required for CNS-C and RN-D since they were nurses.</p> <p>On February 28, 2024, at 1:24 p.m., licensed assisted living director (LALD)-H and administrator (A)-B both stated they did not know anything about the training documents requested, they stated HM/ULP-A handles training and training documents.</p> <p>On February 29, 2024, at 10:42 a.m., HM/ULP-A stated they had not completed the required statute training. HM/ULP-A stated they were currently working on Educare modules which they assigned to themselves today (February 29, 2024). They stated they were unable to locate further orientation documentation for CNS-C or RN-D.</p> <p>The licensee's Agency Employee Orientation, undated and referenced Minnesota (MN) Statute 144A.4796, Subd. 1, indicated:<br/>"POLICY:<br/>All employees of the Comprehensive Home Care Agency, including those who provide direct care, supervision of direct care, or management of services for the Agency, shall complete an orientation to home care requirements before providing home care services to clients. If any volunteers provide services to home care clients, they also will receive orientation to home care.<br/>PURPOSE:<br/>To comply with the home care licensure law<br/>To assure that all employees providing or supervising direct care have completed orientation.</p> | 01470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01470                                                        | Continued From page 53<br><br>SPECIAL INSTRUCTIONS:<br>1. The state required orientation to home care must include the following topics:<br>a. An overview of Minnesota's home care law (MN Statutes 144A.43 to 144.4798)<br>b. An introduction and review of all of agency's policies and procedures related to the provision of home care services<br>c. Handling of emergencies and use of emergency services<br>d. Reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes 626.556 and 626.557<br>e. The home care bill of rights (Minnesota Statutes 144A.44)<br>1) Overview of the home care statute and licensure rules.<br>2) Handling of emergencies and use of emergency services.<br>3) Reporting the maltreatment of vulnerable minors or adults.<br>4) Home Care Bill of Rights.<br>5) Handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints and CEP.<br>6) Consumer advocacy services of the Ombudsman for Long-Term care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates and other relevant advocacy services<br>7) A review of the types of home care services the employee will be providing and the scope of the agency's services under the specific license.<br>a. Completion of the orientation training shall be documented in the employee's personnel file.<br>b. Additional orientation shall be provided for employees who provide direct care services | 01470                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01470                                                        | Continued From page 54<br><br>which includes, but is not limited to, the following areas:<br>1) Overview of Agency concept, operation and services<br>a) Goals, philosophy and objectives<br>b) Organizational structure<br>c) Various disciplines (personnel within each)<br>2) Agency personnel policies<br>a) Review policy manual<br>b) Review employee handbook<br>c) Complete necessary forms<br>- I-9 form<br>- W-4 form<br>d) Current TB testing (refer to Health Screening Policy)<br>e) Photocopy of:<br>- Professional license/certification<br>- CPR certificate (if applicable)<br>- Proper ID for I-9 verification<br>f) EEO Compliance<br>3) Orientation to clinical and written procedures<br>a) Position description-employee must sign<br>b) General Administrative Policies<br>c) Skills demonstration checklist (per agency guidelines)<br>d) Professional Orientation Materials<br>- Daily/Weekly routine<br>- Recording procedure<br>- Conferences with supervisors<br>- Conferences between disciplines<br>- Discharge policy<br>- Role of unlicensed personnel in conjunction with responsibilities of professional staff<br>- Chart format -- various forms used within chart -- forms used in other disciplines.<br>4) Infection Control/OSHA Blood Borne Pathogen Policies<br>5) Advance Directives/DNR-DNI-Health Care Directive and POLST<br>6) HIPAA and Privacy Policies" | 01470                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01470                                                        | Continued From page 55<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 01470                                                                                        |                                                                                                                          |  |                                              |
| 01500<br>SS=D                                                | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must<br>complete at least eight hours of annual training<br>for each 12 months of employment. The training<br>may be obtained from the facility or another<br>source and must include topics relevant to the<br>provision of assisted living services. The annual<br>training must include:<br>(1) training on reporting of maltreatment of<br>vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and<br>staff responsibilities related to ensuring the<br>exercise and protection of those rights;<br>(3) review of infection control techniques used in<br>the home and implementation of infection control<br>standards including a review of hand washing<br>techniques; the need for and use of protective<br>gloves, gowns, and masks; appropriate disposal<br>of contaminated materials and equipment, such<br>as dressings, needles, syringes, and razor<br>blades; disinfecting reusable equipment;<br>disinfecting environmental surfaces; and<br>reporting communicable diseases;<br>(4) effective approaches to use to problem solve<br>when working with a resident's challenging<br>behaviors, and how to communicate with<br>residents who have dementia, Alzheimer's<br>disease, or related disorders;<br>(5) review of the facility's policies and procedures<br>relating to the provision of assisted living services<br>and how to implement those policies and<br>procedures; and | 01500                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                               | <p>Continued From page 56</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment in the required annual training topics for one of two employees (house manager/unlicensed personnel (HM/ULP)-A).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of</p> | 01500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                               | <p>Continued From page 57</p> <p>residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>HM/ULP-A was hired on May 20, 2018, to provide direct cares to residents and manage the licensee.</p> <p>On February 26, 27 and 28, 2024, the surveyor observed HM/ULP-A providing cares and managing the licensee throughout the survey.</p> <p>HM/ULP-A's employee record included an Educare (online training platform) transcript which indicated HM/ULP-A lacked eight hours of annual training in the following topics which were last completed in 2020:</p> <ul style="list-style-type: none"><li>-Infection control techniques;</li><li>-Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</li><li>-Review of provider's policies and procedures; and</li><li>-Principles of person-centered planning/service delivery.</li></ul> <p>On February 28, 2024, at 1:24 p.m., licensed assisted living director (LALD)-H and administrator (A)-B stated they did not know where training documents were for HM/ULP-A. They stated HM/ULP-A handled assigned training and training documents.</p> <p>On February 29, 2024, at 10:42 a.m., HM/ULP-A stated they did not complete the above mentioned required annual training. HM/ULP-A</p> | 01500                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01500                                                               | Continued From page 58<br><br>stated they were currently working on Educare training modules which they assigned to themselves today (February 29, 2024). They stated they were not sure who was in charge of scheduling annual training, but they were took care of theirs today.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01500                                                                                                |                                                                                                                          |  |                                                        |
| 01530<br>SS=F                                                       | <b>144G.64 TRAINING IN DEMENTIA CARE<br/>REQUIRED</b><br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.<br>Direct-care employees must have at least two | 01530                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01530                                                               | <p>Continued From page 59</p> <p>hours of training on topics related to dementia for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to provide employees with two hours of required annual dementia care training for two of four direct care employees (registered nurse (RN)-D, house manager/unlicensed personnel (HM/ULP)-A). Further, the licensee failed to provide employees with eight hours of initial dementia care training at the time of hire for one of four employees (marketing manager/ULP (MM/ULP)-G).</p> <p>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).</p> <p>The findings include:</p> <p>RN-D<br/>RN-D was hired on June 5, 2023, to provide direct cares to residents and oversight to ULPs.</p> <p>RN-D's employee record included an Educare (online training platform) transcript which indicated RN-D last completed dementia training on May 15, 2021, while working for a previous employer. RN-D's annual dementia training was due to be completed by May 15, 2022. RN-D had not received dementia care training while employed with the current licensee.</p> | 01530                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b>                     |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01530                                                               | <p>Continued From page 60</p> <p>On February 26, 2024, at 12:11 p.m., RN-D stated they had been employed with the licensee since the summer of 2023 and was currently the on-call nurse in the event the current clinical nurse supervisor (CNS) was unable to perform their duties.</p> <p>HM/ULP-A<br/>HM/ULP-A was hired on May 20, 2018, to provide direct cares to residents and manage the licensee.</p> <p>HM/ULP-A was observed providing cares and managing the licensee throughout the survey on February 26, 27, and 28, 2024.</p> <p>HM/ULP-A's employee record included an Educare transcript which indicated HM/ULP-A last completed dementia training on November 29, 2022. HM/ULP-A's annual dementia training was due to be completed by November 29, 2023.</p> <p>MM/ULP-G<br/>MM/ULP-G was hired on June 7, 2020, to work in marketing and provide direct cares to residents.</p> <p>MM/ULP-G's employee record included an Educare transcript which indicated MM/ULP-G completed their orientation and some competency training on May 19 through 23, 2023. They had zero hours of dementia training.</p> <p>On February 28, 2024, at 9:45 a.m., owner/licensed practical nurse (O/LPN)-F stated they did not think dementia training was required for CNS-C and RN-D since they were nurses.</p> <p>On February 28, 2024, at 10:20 a.m., O/LPN-F stated MM/ULP-G was their marketing manager and was also trained last year to work as a ULP.</p> | 01530                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01530                                                        | Continued From page 61<br><br>O/LPN-F and administrator (A)-B both stated MM/ULP-G had worked multiple shifts on multiple occasions and were expected to step in and help, when necessary, with resident cares. O/LPN-F stated the only training completed by MM/ULP-G was completed in Educare and had no further dementia training to provide.<br><br>On February 28, 2024, at 1:24 p.m., licensed assisted living director (LALD)-H and A-B stated they did not know where training documents were for HM/ULP-A. They stated HM/ULP-A handled assigned training and training documents.<br><br>On February 29, 2024, at 10:42 a.m., HM/ULP-A stated they had not completed the required annual dementia training. HM/ULP-A stated they were currently working on the dementia training Educare modules which they assigned to themselves today (February 29, 2024). They stated they were unable to locate dementia care training documentation for RN-D.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530                                                                                        |                                                                                                                          |  |                                              |
| 01620<br>SS=F                                                | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 01620                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01620                                                        | <p>Continued From page 62</p> <p>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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R1 and R2).</p> <p>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).</p> <p>The findings include:</p> <p>R1<br/>R1 admitted to the licensee on December 7,</p> | 01620                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01620                                                        | <p>Continued From page 63</p> <p>2020, and began receiving assisted living services.</p> <p>R1's diagnosis included bipolar disorder, schizophrenia, depression, and traumatic brain injury.</p> <p>R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with medication administration, bathing, dressing, grooming, housekeeping, laundry, meals assistant, behavior management, and safety checks. The service plan also indicated resident reassessment and monitoring will be conducted by the registered nurse no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. An assisted living facility will conduct a nursing assessment during the weekend for a resident who is ready to be discharged from the hospital and return to the facility.</p> <p>R1's record included 90-day nursing assessments dated May 4, 2023, September 4, 2023, and January 13, 2024. The assessment completed on September 4, 2023, was 33 days past the 90-calendar day requirement. The assessment completed on January 13, 2024, was 42 days past the 90-calendar day requirement.</p> <p>R2<br/>R2 admitted to the licensee on March 20, 2022, and began receiving assisted living services.</p> <p>R2's diagnosis included borderline personality disorder with hallucination (primary), seizure disorder, legally blind - left eye, migraine</p> | 01620                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01620                                                        | <p>Continued From page 64</p> <p>headaches, Tourette syndrome, dysphoria gender adolescent or adult.</p> <p>R2's undated Planned Services form, indicated R2 received assistance with bathing reminders, grooming, housekeeping, laundry, meals assistant, behavior management, and safety checks.</p> <p>R2's record included admission assessment dated March 25, 2022, which was late by five days, and a 14-day assessment dated April 14, 2022, which was late by 11 days. 90-day nursing assessments dated October 5, 2022, May 11, 2023, and February 8, 2024, were late by 84 days, 128 days, and 184 days, respectively.</p> <p>On February 27, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated they started working with the company recently and they have noticed the gap in assessments and completed 90-day assessments on both residents recently.</p> <p>The licensee was utilizing a Nursing Assessment and Reassessment of Clients Policy intended for Statutes 144A and not intended for use of Statutes 144G. The licensee's undated policy, read, "An RN will complete a nursing assessment of each Comprehensive home care client within five days of the initiation of home care services. The assessment will be the basis for the service plan that the RN will recommend to the client and the basis for the care plan that staff will follow when implementing the client's services. The client will be reassessed at least every 90 days and the eservice plan will be adjusted as needed. The RN will review the nursing assessment and service plan and, if necessary, will update the assessment and service plan, whenever the client has returned from a hospital or nursing home</p> | 01620                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01620                                                        | Continued From page 65<br><br>stay, has a change in condition or experiences an incident such as a fall."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 01620                                                                                        |                                                                                                                          |  |                                              |
| 01760<br>SS=F                                                | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to follow appropriate medication administration procedures and failed to administer medications according to provider orders for one of one resident (R1). In addition, the licensee failed to accurately document medication administration for one of one resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01760                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01760                                                        | <p>Continued From page 66</p> <p>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).</p> <p>The findings include:</p> <p>R1 was admitted to the licensee on December 7, 2020, and began receiving assisted living services.</p> <p>R1's diagnosis included bipolar disorder, schizophrenia, depression, and traumatic brain injury.</p> <p>R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with medication administration, bathing, dressing, grooming, housekeeping, laundry, meals assistant, behavior management, and safety checks.</p> <p>OMISSION ERROR</p> <p>R1's Med Amin Summary - Actual - Month dated February 1, 2024, through February 27, 2024, indicated R1 was to be administered the following medication every day at 8:00a.m.:</p> <ul style="list-style-type: none"><li>-Bupropion 300milligram (mg);</li><li>-Celecoxib 200mg;</li><li>-Cetirizine 10mg;</li><li>-clotrimazole 1% cream 30 gram (gm);</li><li>-Gabapentin 900mg;</li><li>-Fluticasone nasal spray 50 microgram (mcg ) 2 sprays in each nostril;</li><li>-Ipratropium/albuterol inhale solution nebulize and inhale 1 vial;</li></ul> | 01760                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01760                                                        | <p>Continued From page 67</p> <p>-Metformin 500mg;<br/>-Potassium chloride 20 milliequivalent (meq);<br/>-Propranolol 120mg;<br/>-Terbinafine 250mg;<br/>-Topiramate 250mg;<br/>-Venlafaxine 75mg;<br/>-Ellipta 200 mcg/62.5 mcg/25mcg; and<br/>-Vitamin D3 50mcg</p> <p>On February 27, 2024, at 8:17 a.m., the surveyor observed housing manager/unlicensed personnel (HM/ULP)-A remove R1's medication cards from the locked file cabinet, bring them to the table by the computer screen sign into the electronic medication administration record (EMAR), and start preparing R1's medication. HM/ULP-A verified resident's name, medication name, expiration dates, dosage, and time of administration against the EMAR one at a time, removed medications and set them up in a medication cup. HM/ULP-A checked pharmacy label on Albuterol Sulfate 90mcg HFA inhalation Aerosol and compared it with Ipratropium/albuterol inhale solution and stated the order said one vile but the label on the Albuterol Sulfate 90mcg HFA inhalation Aerosol said two puffs. HM/ULP-A then stated the instruction was not correct and they would let the nurse know before administering the medication and set the medication aside. Surveyor inquired the ULP to demonstrate how they would administer Ipratropium/albuterol inhale solution. HM/ULP-A stated they would shake the medication give it to R1, R1 takes two puffs and gives it right back to them. After they were done preparing R1's medication, HM/ULP-A gave the medication to R1, R1 took all medication and asked if they could have the inhaler that they take every morning. HM/ULP-A then handed the Albuterol Sulfate 90mcg, and stated it is an as</p> | 01760                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01760                                                        | <p>Continued From page 68</p> <p>needed (PRN) medication. Surveyor asked R1 if they had been taking the Albuterol Sulfate 90mcg every day. R1 stated they take the PRN Albuterol Sulfate 90mcg everyday "my asthma is acting up".</p> <p>On February 27, 2024, at 8:45 a.m., surveyor inquired if R1 had nebulizing machine. HM/ULP-A did not know what a nebulizing machine was, surveyor explained what the machine looked like, and HM/ULP-A stated yes, R1 has it in their bedroom. Surveyor and HM/ULP-A went to R1's room but was unable to find the machine. Surveyor then asked R1, who was sitting outside smoking, if they had nebulizing machine. R1 stated they had not used it for the last two months, but the machine was in the medication drawer. R1 directed HM/ULP-A to the bottom drawer of the first medication cabinet, in the living room. HM/ULP-A opened the drawer and surveyor observed nebulizer machine and two opened packages of Ipratropium/albuterol inhale solution. HM/ULP-A stated they use the nebulizing machine only when R1's asthma acts up.</p> <p>R1's Med Amin Summary - Actual - Month dated February 1, 2024, through February 26, 2024, indicated R1 had taken Ipratropium/albuterol inhale solution every day, except February 3, 5, 8, 12, 21, 22, and 23, and R1 had not taken the PRN Albuterol Sulfate 90mcg from February 1, 2024, through February 26, 2024.</p> <p>R1 had not been receiving Ipratropium/albuterol inhale nebulize solution, however, the licensee's charting for the month of February reflected R1 had received the medication for 18 days out 26 days.</p> | 01760                                                                                        |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429                             |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 01760                                                        | <p>Continued From page 69</p> <p>On February 27, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)- C stated they were not aware R1 was not getting lpratropium/albuterol inhale solution, and also stated it was their expectation that ULPs chart not given when medications were not administered, and chart as given when PRNs are administered.</p> <p>LACK OF DOCUMENTATION</p> <p>R1's Med Amin Summary - Actual - Month dated February 1, 2024, through February 26, 2024, lacked medication administration documentation for the following medication administration opportunities during multiple shifts:</p> <p>8:00 a.m. Administration</p> <ul style="list-style-type: none"><li>-8/26 Bupropion 300milligram (mg);</li><li>-6/26 Omeprazole 20mg;</li><li>-8/26 Celecoxib 200mg;</li><li>-8/26 Cetirizine 10mg;</li><li>-8/26 clotrimazole 1% cream 30 gram (gm);</li><li>-8/26 Gabapentin 900mg;</li><li>-8/26 Fluticasone nasal spray 50 microgram (mcg ) 2 sprays in each nostril;</li><li>-8/26 lpratropium/albuterol inhale Sol nebulize and inhale 1 vial;</li><li>-8/26 Metformin 500mg;</li><li>-8/26 Potassium chloride 20 milliequivalent (meq);</li><li>-8/26 Propranolol 120mg;</li><li>-8/26 Terbinafine 250mg;</li><li>-8/26 Topiramate 250mg;</li><li>-8/26 Venlafaxine 75mg;</li><li>-8/26 Ellipta 200 mcg/62.5 mcg/25mcg;</li><li>-8/26 Vitamin D3 50mcg;</li></ul> <p>12:00 p.m. Administration</p> <ul style="list-style-type: none"><li>-14/26 Aquaphor Ointment;</li><li>-14/26 Gabapentin 800mg</li></ul> | 01760                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01760                                                               | <p>Continued From page 70</p> <p>1:00 p.m. Administration<br/>-14/26 Atorvastatin 20mg</p> <p>p.m. Administration<br/>-4/4 Wegovy injection 0.25mg;</p> <p>8:00 p.m Administration<br/>-9/26 clotrimazole 1% cream 30 gram (gm);<br/>-10/26 Gabapentin 900mg;<br/>-8/26 Metformin 500mg;<br/>-8/26 Montelukast 10mg;<br/>-8/26 Risperidone 2mg;</p> <p>On February 27, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-C stated they are aware there are some gaps in medication and service administration charting for all residents and stated they just started with the company, and they would work on fixing the problems.</p> <p>On February 29, 2024, at 10:25 a.m., surveyor inquired to HM/ULP-A if R1 had received their medications every day as per the order. HM/ULP-A stated the medications had been given but they did not know why it was not charted. "When I am in the house there is a lot of behavior and maybe I was out my mind and forgot to chart."</p> <p>The licensee's undated Medication Management Services policy dated read, "Review of the Client's Medication Record. The RN or LPN will review each client's medication record when the nurse is setting up medications and at other appropriate times based on the client's needs and the client's medication management services, including during the client monitoring visit, to verify that:</p> <p>a. Staff is administering the medications as</p> | 01760                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | <p>Continued From page 71</p> <p>prescribed and is documenting the administration appropriately with authentication by each staff person by discipline or title.</p> <p>b. To review and evaluate the administration of PRN medications.</p> <p>c. To observe signs of medication diversion and</p> <p>d. To evaluate the effectiveness of the medications and identify any drug-to-drug interaction, and untoward or reported side effects. Any issues or concerns will require follow up and documentation by the nurse, including communications with the prescriber and pharmacy, education of the client and/or the client's representative, and additional training for staff or other appropriate actions."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01760                                                                                                |                                                                                                                          |  |                                                     |
| 01890<br>SS=F                                                       | <p><b>144G.71 Subd. 20 Prescription drugs</b></p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened for one of two residents (R1).</p> <p>This practice resulted in a level two violation (a</p>                                                                                                                                                    | 01890                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                      |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34526</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01890                                                               | <p>Continued From page 72</p> <p>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).</p> <p>The findings include:</p> <p>On February 27, 2024, at approximately 7:55 a.m., the surveyor observed the medication cart and observed the following time sensitive medication was opened without opened on date label:<br/>- R1's Trelegy Ellipta 200 mcg/62.5 mcg/25mcg inhaler.</p> <p>On February 27, 2024, at 8:42 a.m., housing manger/unlicensed personnel (HM/ULP)-A verified there was no label on the medication and stated they were never educated by the registered nurse (RN) to label inhalers with opened-on date, but they were educated to label medication with the resident's name and to put their initial on the label.</p> <p>On February 27, 2024, at 12:14 p.m., RN-C stated they were not aware inhalers needed an opened-on date, but it was their expectation that all medications were labeled with resident's name.</p> <p>The manufacturer's instructions for the use of Trelegy Ellipta 200 mcg/62.5 mcg/25mcg inhaler last revised September 2023, directed the Trelegy Ellipta 200 mcg/62.5 mcg/25mcg inhaler to be discarded after 6 weeks, starting from the date of opening the tray.</p> | 01890                                                                                                |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34526</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EMPIRE SYSTEMS HOME CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6012 YORK AVENUE NORTH<br/>BROOKLYN CENTER, MN 55429</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01890                                                               | Continued From page 73<br><br>The licensee's undated Medication Storage Policy read, "Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                         | 01890                                                                                                |                                                                                                                          |  |                                                        |
| 02400<br>SS=C                                                       | 144G.91 Subd. 12 Visitors and social participation<br><br>(a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan.<br>(b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents.<br><br>This MN Requirement is not met as evidenced | 02400                                                                                                |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>34526                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>02/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EMPIRE SYSTEMS HOME CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6012 YORK AVENUE NORTH<br>BROOKLYN CENTER, MN 55429 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 02400                                                        | <p>Continued From page 74</p> <p>by:<br/>Based on observation and interview, the licensee failed to respect the resident's right to receive visits at any time. This had the potential to affect all residents at the facility.</p> <p>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).</p> <p>The findings include:</p> <p>On February 26, 2024, at 9:35 a.m., surveyor observed a sign posted by the front door indicating visiting hours were from 11:00 a.m. to 6:00 p.m.</p> <p>On February 28, 2024, at 11:55 p.m., owner/licensed practical nurse (O/LPN)-F stated "I know under the other license we could do visiting hours but under the new rule we cannot do that I read. That is something we have to adjust. The residents are free to have their friends and family come over."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 02400                                                                                        |                                                                                                                          |  |                                              |





Minnesota Department of Health  
Food, Pools and Lodging Services Section  
625 N Robert St  
St Paul, MN 55164  
651-201-4500

Type: Full  
Date: 02/27/24  
Time: 14:14:55  
Report: 7963241022

## Food and Beverage Establishment Inspection Report

Page 1

### Location:

Empire Systems Home Care  
6012 York Avenue North  
Brooklyn Center, MN55430  
Hennepin County, 27

### Establishment Info:

ID #: 0038850  
Risk:  
Announced Inspection: No

### License Categories:

Expires on: / /

### Operator:

Phone #: 7632372402  
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.

### 4-300 Equipment Numbers and Capacities

#### 4-302.12B **\*\* Priority 2 \*\***

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON SITE.

Comply By: 02/27/24

### 2-100 Supervision

#### 2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

A COPY OF A CERTIFIED FOOD MANAGER CERTIFICATE WAS POSTED ON SITE. POST ORIGINAL CERTIFICATE.

Comply By: 02/27/24

### Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit

Location: DISHWASHER RINSE

Violation Issued: No

### Food and Equipment Temperatures

Process/Item: MILK

Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No



Type: Full  
Date: 02/27/24  
Time: 14:14:55  
Report: 7963241022  
Empire Systems Home Care

# Food and Beverage Establishment Inspection Report

Page 2

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

MET WITH GRACE KEMOKAI AND MDH NURSE SURVEYORS DEE MOSISSA AND JOEY KEEN.  
DISCUSSED THE FOLLOWING-

- EMPLOYEE ILLNESS POLICY AND LOG
- REPORTABLE DISEASES
- CERTIFIED FOOD MANAGER CERTIFICATE
- PROPER WASHING AND SANITIZING OF DISHES AND UTENSILS
- PROPER COOKING OF EGGS AND MEAT
- HIGHLY SUSCEPTIBLE POPULATION REQUIREMENTS
- SAME DAY SERVICE OF FOOD

THIS IS A RESIDENTIAL SETTING WITH A DISHWASHER THAT HAS A SANITIZER CYCLE. THIS  
LOCATION USES SAME-DAY SERVICE FOR ALL FOODS.

KITCHEN HAS LINOLEUM FLOORING, WOOD CABINETS, LAMINATE COUNTERTOPS AND A  
SMOOTH, PAINTED CEILING.

FACT SHEETS SENT WITH REPORT.

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

I acknowledge receipt of the Minnesota Department of Health inspection report  
number 7963241022 of 02/27/24.

Certified Food Protection Manager Emmanuel Wheagar

Certification Number: FM 108016 Expires: 08/28/24

**Inspection report reviewed with person in charge and emailed.**

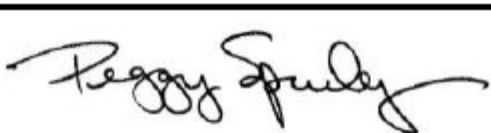
Signed: \_\_\_\_\_

Gbessay Grace Kemokai  
PIC

Signed:  \_\_\_\_\_

Peggy Spadafore  
Sanitarian Supervisor  
metro  
651-201-4500  
peggy.spadafore@state.mn.us



|                                                                                                                                                                         |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------|-----|-----|------------------------------------------|--|--|
| Report #: 7963241022                                                                                                                                                    |                                                                                                                    | Food Establishment Inspection Report |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| <br>DEPARTMENT OF HEALTH                                                                | Minnesota Department of Health<br>Food, Pools and Lodging Services Section<br>625 N Robert St<br>St Paul, MN 55164 |                                      | No. of RF/PHI Categories Out                                                        |                                                                                 | 1                                                                                          | Date 02/27/24                 |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
|                                                                                                                                                                         |                                                                                                                    |                                      | No. of Repeat RF/PHI Categories Out                                                 |                                                                                 | 0                                                                                          |                               | Time In 14:14:55                                                                                                                                                                                                                                                |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
|                                                                                                                                                                         |                                                                                                                    |                                      | Legal Authority MN Rules Chapter 4626                                               |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 | Time Out                                                     |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Empire Systems Home Care                                                                                                                                                | Address<br>6012 York Avenue North                                                                                  |                                      | City/State<br>Brooklyn Center, MN                                                   |                                                                                 | Zip Code<br>55430                                                                          | Telephone<br>7632372402       |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| License/Permit #<br>0038850                                                                                                                                             | Permit Holder                                                                                                      |                                      | Purpose of Inspection<br>Full                                                       |                                                                                 | Est Type                                                                                   | Risk Category                 |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS                                                                                                          |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item                                                                                          |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Mark "X" in appropriate box for COS and/or R                                                                                                                            |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| IN= in compliance    OUT= not in compliance    N/O= not observed    N/A= not applicable    COS=corrected on-site during inspection    R= repeat violation               |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Compliance Status                                                                                                                                                       |                                                                                                                    |                                      | COS                                                                                 | R                                                                               | Compliance Status                                                                          |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Supervision                                                                                                                                                             |                                                                                                                    |                                      |                                                                                     |                                                                                 | Time/Temperature Control for Safety                                                        |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 1                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | PIC knowledgeable; duties & oversight                                               |                                                                                 |                                                                                            | 18                            | IN                                                                                                                                                                                                                                                              | OUT                                                          | N/A                                                             | N/O                                                                                | Proper cooking time & temperature                     |                                             |     |     |                                          |  |  |
| 2                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | N/A                                                                                 | Certified food protection manager, duties                                       |                                                                                            |                               | 19                                                                                                                                                                                                                                                              | IN                                                           | OUT                                                             | N/A                                                                                | N/O                                                   | Proper reheating procedures for hot holding |     |     |                                          |  |  |
| Employee Health                                                                                                                                                         |                                                                                                                    |                                      |                                                                                     |                                                                                 | 20                                                                                         |                               | IN                                                                                                                                                                                                                                                              | OUT                                                          | N/A                                                             | N/O                                                                                | Proper cooling time & temperature                     |                                             |     |     |                                          |  |  |
| 3                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | Mgmt/Staff;knowledge,responsibilities&reporting                                     |                                                                                 |                                                                                            | 21                            | IN                                                                                                                                                                                                                                                              | OUT                                                          | N/A                                                             | N/O                                                                                | Proper hot holding temperatures                       |                                             |     |     |                                          |  |  |
| 4                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | Proper use of reporting, restriction & exclusion                                    |                                                                                 |                                                                                            | 22                            | IN                                                                                                                                                                                                                                                              | OUT                                                          | N/A                                                             |                                                                                    | Proper cold holding temperatures                      |                                             |     |     |                                          |  |  |
| 5                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | Procedures for responding to vomiting & diarrheal events                            |                                                                                 |                                                                                            | 23                            | IN                                                                                                                                                                                                                                                              | OUT                                                          | N/A                                                             | N/O                                                                                | Proper date marking & disposition                     |                                             |     |     |                                          |  |  |
| Good Hygienic Practices                                                                                                                                                 |                                                                                                                    |                                      |                                                                                     |                                                                                 | 24                                                                                         |                               | IN                                                                                                                                                                                                                                                              | OUT                                                          | N/A                                                             | N/O                                                                                | Time as a public health control: procedures & records |                                             |     |     |                                          |  |  |
| 6                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | N/O                                                                                 | Proper eating, tasting, drinking, or tobacco use                                |                                                                                            |                               | Consumer Advisory                                                                                                                                                                                                                                               |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 7                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | N/O                                                                                 | No discharge from eyes, nose, & mouth                                           |                                                                                            |                               | 25                                                                                                                                                                                                                                                              | IN                                                           | OUT                                                             | N/A                                                                                | Consumer advisory provided for raw/undercooked food   |                                             |     |     |                                          |  |  |
| Preventing Contamination by Hands                                                                                                                                       |                                                                                                                    |                                      |                                                                                     |                                                                                 | 26                                                                                         |                               | IN                                                                                                                                                                                                                                                              | OUT                                                          | N/A                                                             |                                                                                    | Pasteurized foods used; prohibited foods not offered  |                                             |     |     |                                          |  |  |
| 8                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | N/O                                                                                 | Hands clean & properly washed                                                   |                                                                                            |                               | Food and Color Additives and Toxic Substances                                                                                                                                                                                                                   |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 9                                                                                                                                                                       | IN                                                                                                                 | OUT                                  | N/A                                                                                 | N/O                                                                             | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    | 27                                                    | IN                                          | OUT | N/A | Food additives: approved & properly used |  |  |
| 10                                                                                                                                                                      | IN                                                                                                                 | OUT                                  |                                                                                     | Adequate handwashing sinks supplied/accessible                                  |                                                                                            |                               | 28                                                                                                                                                                                                                                                              | IN                                                           | OUT                                                             |                                                                                    | Toxic substances properly identified, stored, & used  |                                             |     |     |                                          |  |  |
| Approved Source                                                                                                                                                         |                                                                                                                    |                                      |                                                                                     |                                                                                 | 29                                                                                         |                               | IN                                                                                                                                                                                                                                                              | OUT                                                          | N/A                                                             |                                                                                    | Compliance with variance/specialized process/HACCP    |                                             |     |     |                                          |  |  |
| 11                                                                                                                                                                      | IN                                                                                                                 | OUT                                  |                                                                                     | Food obtained from approved source                                              |                                                                                            |                               | <div>Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. <b>Public Health Interventions</b> (PHI) are control measures to prevent foodborne illness or injury.</div> |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 12                                                                                                                                                                      | IN                                                                                                                 | OUT                                  | N/A                                                                                 | N/O                                                                             | Food received at proper temperature                                                        |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 13                                                                                                                                                                      | IN                                                                                                                 | OUT                                  |                                                                                     | Food in good condition, safe, & unadulterated                                   |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 14                                                                                                                                                                      | IN                                                                                                                 | OUT                                  | N/A                                                                                 | N/O                                                                             | Required records available; shellstock tags, parasite destruction                          |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Protection from Contamination                                                                                                                                           |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 15                                                                                                                                                                      | IN                                                                                                                 | OUT                                  | N/A                                                                                 | N/O                                                                             | Food separated and protected                                                               |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 16                                                                                                                                                                      | IN                                                                                                                 | OUT                                  | N/A                                                                                 |                                                                                 | Food contact surfaces: cleaned & sanitized                                                 |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 17                                                                                                                                                                      | IN                                                                                                                 | OUT                                  |                                                                                     | Proper disposition of returned, previously served, reconditioned, & unsafe food |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| GOOD RETAIL PRACTICES                                                                                                                                                   |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.                                       |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Mark "X" in box if numbered item is not in compliance    Mark "X" in appropriate box for COS and/or R    COS=corrected on-site during inspection    R= repeat violation |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Safe Food and Water                                                                                                                                                     |                                                                                                                    |                                      | COS                                                                                 | R                                                                               | Proper Use of Utensils                                                                     |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 30                                                                                                                                                                      | IN                                                                                                                 | OUT                                  | N/A                                                                                 | Pasteurized eggs used where required                                            |                                                                                            |                               | 43                                                                                                                                                                                                                                                              |                                                              | In-use utensils: properly stored                                |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 31                                                                                                                                                                      |                                                                                                                    |                                      | Water & ice obtained from an approved source                                        |                                                                                 |                                                                                            |                               | 44                                                                                                                                                                                                                                                              |                                                              | Utensils, equipment & linens: properly stored, dried, & handled |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 32                                                                                                                                                                      | IN                                                                                                                 | OUT                                  | N/A                                                                                 | Variance obtained for specialized processing methods                            |                                                                                            |                               | 45                                                                                                                                                                                                                                                              |                                                              | Single-use/single service articles: properly stored & used      |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Food Temperature Control                                                                                                                                                |                                                                                                                    |                                      |                                                                                     |                                                                                 | 46                                                                                         |                               |                                                                                                                                                                                                                                                                 |                                                              | Gloves used properly                                            |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 33                                                                                                                                                                      |                                                                                                                    |                                      | Proper cooling methods used; adequate equipment for temperature control             |                                                                                 |                                                                                            | Utensil Equipment and Vending |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 34                                                                                                                                                                      | IN                                                                                                                 | OUT                                  | N/A                                                                                 | N/O                                                                             | Plant food properly cooked for hot holding                                                 |                               |                                                                                                                                                                                                                                                                 | 47                                                           |                                                                 | Food & non-food contact surfaces cleanable, properly designed, constructed, & used |                                                       |                                             |     |     |                                          |  |  |
| 35                                                                                                                                                                      | IN                                                                                                                 | OUT                                  | N/A                                                                                 | N/O                                                                             | Approved thawing methods used                                                              |                               |                                                                                                                                                                                                                                                                 | 48                                                           |                                                                 | Warewashing facilities: installed, maintained, & used; test strips                 |                                                       |                                             |     |     |                                          |  |  |
| 36                                                                                                                                                                      | X                                                                                                                  |                                      | Thermometers provided & accurate                                                    |                                                                                 |                                                                                            | 49                            |                                                                                                                                                                                                                                                                 |                                                              |                                                                 | Non-food contact surfaces clean                                                    |                                                       |                                             |     |     |                                          |  |  |
| Food Identification                                                                                                                                                     |                                                                                                                    |                                      |                                                                                     |                                                                                 | Physical Facilities                                                                        |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 37                                                                                                                                                                      |                                                                                                                    |                                      | Food properly labeled; original container                                           |                                                                                 |                                                                                            | 50                            |                                                                                                                                                                                                                                                                 | Hot & cold water available; adequate pressure                |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Prevention of Food Contamination                                                                                                                                        |                                                                                                                    |                                      |                                                                                     |                                                                                 | 51                                                                                         |                               | Plumbing installed; proper backflow devices                                                                                                                                                                                                                     |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 38                                                                                                                                                                      |                                                                                                                    |                                      | Insects, rodents, & animals not present                                             |                                                                                 |                                                                                            | 52                            |                                                                                                                                                                                                                                                                 | Sewage & waste water properly disposed                       |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 39                                                                                                                                                                      |                                                                                                                    |                                      | Contamination prevented during food prep, storage & display                         |                                                                                 |                                                                                            | 53                            |                                                                                                                                                                                                                                                                 | Toilet facilities: properly constructed, supplied, & cleaned |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 40                                                                                                                                                                      |                                                                                                                    |                                      | Personal cleanliness                                                                |                                                                                 |                                                                                            | 54                            |                                                                                                                                                                                                                                                                 | Garbage & refuse properly disposed; facilities maintained    |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 41                                                                                                                                                                      |                                                                                                                    |                                      | Wiping cloths: properly used & stored                                               |                                                                                 |                                                                                            | 55                            |                                                                                                                                                                                                                                                                 | Physical facilities installed, maintained, & clean           |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| 42                                                                                                                                                                      |                                                                                                                    |                                      | Washing fruits & vegetables                                                         |                                                                                 |                                                                                            | 56                            |                                                                                                                                                                                                                                                                 | Adequate ventilation & lighting; designated areas used       |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Food Recalls:                                                                                                                                                           |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               | 57                                                                                                                                                                                                                                                              |                                                              | Compliance with MCIAA                                           |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Person in Charge (Signature)                                                                                                                                            |                                                                                                                    |                                      |                                                                                     |                                                                                 |                                                                                            |                               | 58                                                                                                                                                                                                                                                              |                                                              | Compliance with licensing & plan review                         |                                                                                    |                                                       |                                             |     |     |                                          |  |  |
| Inspector (Signature)                                                                                                                                                   |                                                                                                                    |                                      |  |                                                                                 |                                                                                            |                               |                                                                                                                                                                                                                                                                 |                                                              |                                                                 |                                                                                    |                                                       |                                             |     |     |                                          |  |  |