Electronically Delivered

August 28, 2025

Licensee
Empower Center Care
1105 Hazel Street North
Saint Paul, MN 55119

RE: Project Number(s) SL24717016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 9, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addtion to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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 or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L Anderson

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24717	A. BUILDING: _____ B. WING _____	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWER CENTER CARE	1105 HAZEL STREET N SAINT PAUL, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL #24717016-0 On July 7, 2025, through July 9, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 31 residents, all of whom were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470		

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0 470	Continued From page 1 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to review their staffing plan two times annually to determine if staffing levels met the needs of all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 470		

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0 470	Continued From page 2 a large portion or all of the residents). The findings include: The licensee's staffing plan, reviewed October 24, 2024, indicated staffing requirements for each shift were: four staff members for each day and evening shift, and two staff members for the overnight shift. The plan lacked documentation of annual review twice per year. On July 9, 2025, at 10:15 a.m., licensed assisted living director (LALD)-A stated the staffing plan was reviewed once annually when the emergency preparedness plan was reviewed. LALD-A further stated he was not aware the staffing plan needed to be reviewed at least twice a year. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy, January 1, 2025, indicated the staffing plan would be reviewed at least two times a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480		

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0 480	Continued From page 3 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	0 480		

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0 480	Continued From page 4 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 8, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 5 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) blood test was completed and documented for one of three employees (unlicensed personnel (ULP)-G). The licensee further failed to complete a facility TB risk assessment annually. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 660		

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0 660	Continued From page 6 a large portion or all of the residents). The findings include: SCREENING ULP-G was hired January 29, 2024. ULP-G's employee record contained a first step TST, dated January 22, 2023, but lacked documentation of a second step TST being completed. On July 7, 2025, at 3:20 p.m., clinical nurse supervisor (CNS)-B stated most of the staff who were hired before he started needed their second step TST completed, and he was not sure why their second step TST had not been done. CNS-B further stated he did not have a plan in place to get the missing TST completed. FACILITY RISK ASSESSMENT On July 8, 2025, at 11:15 a.m., licensed assisted living director (LALD)-A stated the nurse would have been the one to fill out the TB facility risk assessment and he was not sure if they had a recent one. On July 8, 2025, at 12:00 p.m., CNS-B stated he had not completed a TB facility risk assessment, and he did not know one needed to be completed. The Minnesota Department of Health (MDH) Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH, dated June 2024, indicated a TB facility risk assessment should be performed annually.	0 660		

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0 660	Continued From page 7 The licensee's TB Prevention and Control policy, dated January 1, 2025, indicated the clinical nurse supervisor was responsible for establishing and maintaining the TB prevention and control program. The policy indicated, prior to contact with residents, a two-step TST or an IGRA would be used to screen employees. The policy further indicated the form provided by the Minnesota Department of Health would be used to complete a TB risk assessment annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680		

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0 680	Continued From page 8 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP, reviewed October 9, 2024, lacked evidence of the following required content: - a facility hazard risk assessment - policies/procedures based on the facility risk assessment On July 8, 2025, at 1:00 p.m., licensed assisted living director (LALD)-A stated a hazard risk assessment had not been done, and he did not know one need to be done. The licensee's undated Emergency and Disaster Plan policy indicated the EPP would be created	0 680		

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0 680	Continued From page 9 and updated using a comprehensive, all-hazard approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 9, 2025, at approximately 10:30 a.m., the surveyor toured the facility with maintenance staff (MS)-I. The following was observed.	0 775		

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0 775	Continued From page 10 1. The fire rated door separating the assisted living from the vacant dementia care portion of the facility had a permanent door stop installed and was propped open. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. 2. All the stairway enclosure doors in the facility are rated fire doors with tags on the door frame and hinge side of the door, smoke seal, and closers. The doors were propped open with door wedges. 3. The smoke enclosure doors in the facility have smoke seal, and closers. The doors were propped open with door wedges. 4. The facility was not equipped with carbon monoxide alarms in the dwelling units or mechanical rooms. In multifamily dwellings, approved and operational carbon monoxide alarms may be installed between 15 and 25 feet of carbon monoxide-producing central fixtures and equipment provided there is a centralized alarm system. On July 9, 2025, MS-I acknowledged these conditions while on the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 11 (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire 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. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24717	A. BUILDING: _____ B. WING _____	07/09/2025

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0 810	Continued From page 12 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). The findings include: On July 9, 2025, at approximately 10:30 a.m., survey staff observed the room identification on the fire evacuation diagrams did not match the room identification being used throughout the facility. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On July 9, 2025, maintenance staff (MS)-I provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: 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. During the interview MS-I stated all non-ambulatory residents shall shelter in place until the Fire Department evacuates the resident. The policy states staff shall evacuate all residents. The FSEP did not identify specific fire protection actions for residents. There was no section in the	0 810		

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0 810	Continued From page 13 policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. 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. During the interview MS-I stated stickers are placed on the name plates throughout the facility indicating non-ambulatory resident units. The policy did not outline this identification. On July 9, 2025, MS-I stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. MS-I lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. MS-I stated currently there is not training program for staff on the FSEP. No training documentation was provided. On July 9, 2025, MS-I stated they understood the requirements for training residents and staff. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month.	0 810		

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0 810	Continued From page 14 Record review of licensee's evacuation drill log, indicated an evacuation drill were conducted annually. The evacuation drill in 2025 was dated 4-10-25. On July 9, 2025, at approximately 9:00 a.m., MS-I stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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01060	Continued From page 15 information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, their legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four (4) days for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01060		

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01060	Continued From page 16 The findings include: R3's service plan, dated June 25, 2025, indicated R3 received services including assistance with medication administration. On July 8, 2025, at 7:30 a.m., unlicensed personnel (ULP)-D was observed assisting R3 with medication administration. R3's progress note, dated March 7, 2025, at 1:51 p.m., indicated R3 returned to the facility after being hospitalized from March 3, 2025, to March 7, 2025. R3's record lacked documentation a written notice was provided to the resident, their legal representative, and their designated representative with the following required information: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 17 On July 8, 2025, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated his process was to contact families regarding an emergency relocation when a resident was sent to the hospital, but he did not provide a written notice. CNS-B further stated he used to provide notice to the OOLTC, but he no longer did because he never received a response. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan included a signature or other authentication by the facility and by the resident, or their representative, documenting agreement on the services to be provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 and R3's unsigned service plans, each dated June 25, 2025, indicated R2 and R3 received services including medication administration. On July 8, 2025, at 7:36 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R2 with medication administration. On July 9, 2025, at 10:15 a.m., licensed assisted living director (LALD)-A stated he had all residents or resident representatives sign their initial service plan, but he had not been getting service plans signed with changes or updates. LALD-A further stated there was "no reason in particular" he was not getting them signed. The licensee's Contents of Service Plans policy,	01640		

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01640	Continued From page 19 dated January 1, 2025, indicated the service plan and any revisions would include a signature or other authentication by the licensee and the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document opened dates on time sensitive medication for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01890		

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01890	Continued From page 20 R3's service plan, dated June 25, 2025, indicated R3 received services including assistance with medication administration. R3's record contained a provider's order, dated June 12, 2025, for Tresiba FlexTouch pen (a long-acting insulin used to manage blood sugar levels). Inject 8 units under the skin every morning. On July 8, 2025, at 7:20 a.m., the surveyor observed the licensee's medication cart with unlicensed personnel (ULP)-C. A Tresiba Flex Touch pen was observed in one of R3's medication baskets. The pen had a sticker that read "date opened," but the sticker lacked a written date to indicate when the medication was first used. On July 8, 2025, at 7:20 a.m., ULP-C stated she believed insulin was only good for 28 days after it was opened, and a date should have been written on the pen when it was first used. ULP-C further stated she would contact the nurse. On July 8, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated insulin pens were good for 28 days after they were opened, and he was not sure why it was missing the date opened. The manufacturer's prescribing information for the use of Tresiba insulin injection, dated July 2022, indicated the medication should be discarded 56 days after first use. The licensee's Storage of Medication policy, dated January 1, 2025, indicated medications would be stored consistent with manufacturer's recommendations.	01890		

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01890	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition of discontinued medications for one of one residents (R1).	01910		

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01910	Continued From page 22 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1was admitted to the facility November 1, 2024, and discharged December 11, 2024. R1's Discharge/Transfer Summary dated December 11, 2024, indicated R1 received services including assistance with medication management. R1's record lacked documentation of the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition upon discharge. On July 8, 2025, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated he usually keeps a medication disposition record with the required information for medications, but he did not use one last month because the medications were "piling up." CNS-B further stated he must have forgotten to document the medication disposition for R1. The licensee's Disposition or Disposal of Medication policy, dated January 1, 2025, indicated once medication management services	01910		

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01910	Continued From page 23 ended, staff would document in the residents record the name of the person whom medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required posting at the main entry way of the facility, included statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	03090		

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03090	Continued From page 24 the residents). The findings include: On July 7, 2025, at 11:15 a.m., during a tour of the licensee's facility, the surveyor observed the licensee lacked an electric monitoring notice with the required statutory language. On July 8, 2025, at 11:15 a.m., licensed assisted living director (LALD)-A stated there was not an electronic monitoring notice posted at the front entrance, and he had not aware of the requirement. The licensee's Electronic Monitoring Policy and Procedure policy, dated October 9, 2024, indicated the licensee would post a sign at each facility entrance accessible to visitors that stated, "electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

Empower Center Care
1105 Hazel Street N
St. Paul, MN 55119
Ramsey County
Parcel:

Phone:

License Info

License: HFID 24717

Risk:
License:
Expires on:
CFPM: TONG VANG
CFPM #: CFPM-53932; Exp: 05/29/2027

Inspection Info

Report Number: F1005251048
Inspection Type: Full - Single
Date: 7/8/2025 Time: 10:00:07 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: THERE IS NO EMPLOYEE ILLNESS LOG ON SITE. DISCUSSED EXCLUSION AND RECORDING REQUIREMENTS, BLANK LOG WILL BE EMAILED WITH REPORT.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.12F *Priority Level: Priority 3 CFP#: 43*
MN Rule 4626.0275F Discontinue storing food preparation or dispensing utensils in a container of water that is not maintained at 135 degrees F (57 degrees C) and not cleaned when empty.
COMMENT: SCOOPS FOR RICE WERE STORED IN ROOM TEMPERATURE WATER. IF WATER IS NOT 135 DEGREES F OR HIGHER, THEN SCOOPS MUST BE STORED IN AN EMPTY BIN AND CLEANED AT LEAST EVERY 4 HOURS.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114A *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.
COMMENT: ESTABLISHMENT IS USING CHLOROX WIPES FOR FOOD PREP TABLES. THE PRODUCT LABEL STATES IT MUST BE RINSED WITH POTABLE WATER AFTER WIPING ON A FOOD CONTACT SURFACE, WHICH IS NOT CURRENTLY BEING DONE. RECOMMEND PROVIDING A CHLORINE OR QUATERNARY AMMONIUM SANITIZER FOR FOOD CONTACT SURFACES, AND APPROPRIATE TEST STRIPS.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

Food & Beverage General Comment

INSPECTION COMPLETED WITH FACILITY DIRECTOR AND REVIEWED WITH HRD NURSING EVALUATOR TAMMY CARLSON.

DISCUSSED ALL ORDERS ON REPORT.

REVIEWED SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN AN EMPLOYEE ILLNESS LOG OF THOSE INSTANCES WHEN EMPLOYEES ARE ILL WITH VOMITING OR DIARRHEA "AND" IMMEDIATELY EXCLUDE FROM THE FOOD ESTABLISHMENT ANY FOOD EMPLOYEE ILL WITH VOMITING OR DIARRHEA. EMPLOYEES MUST BE EXCLUDED FOR AT LEAST 24 HOURS AFTER LAST SYMPTOM.

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

I acknowledge receipt of the Metro District Office inspection report number F1005251048 from 7/8/2025

TONG VANG
DIRECTOR

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Empower Center Care
St. Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1005251048
Inspection Type: Full
Date: 7/8/2025
Time: 10:00:07 AM

Food Temperature: Product/Item/Unit: WATERMELON**; Temperature Process:** Cold-Holding
Location: 2-DOOR REACH-IN, NEAR 3-COMP at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: 2-DOOR REACH-IN, NEAR STOVE at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: TOFU**; Temperature Process:** Cold-Holding
Location: 2-DOOR REACH-IN, NEAR STOVE at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: RICE**; Temperature Process:** Hot-Holding
Location: RICE WARMER at 205 Degrees F.
Comment:
Violation Issued?: No

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Sanitizer Observations/Recordings

Establishment Info

Empower Center Care
St. Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1005251048
Inspection Type: Full
Date: 7/8/2025
Time: 10:00:07 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: **Equal To** 171 Degrees F.
Comment:
Violation Issued?: No