



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 6, 2026

Licensee

The Encore at North Branch

38610 14th Avenue

North Branch, MN 55056

RE: Project Number(s) SL30608016

Dear Licensee:

On January 13, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 30, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor

State Engineering Services Section

Email: Tim.Hanna@state.mn.us

Telephone: 507-208-8982 Fax: 1-866-890-9290

CLN



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 15, 2025

Licensee

The Encore at North Branch
38610 14th Avenue
North Branch, MN 55056

RE: Project Number(s) SL30608016

Dear Licensee:

On October 21, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 30, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 30, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 30, 2025, found not corrected at the time of the October 21, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on October 21, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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 addition to any enforcement mechanism authorized in § 144G.20.

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.

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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.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna", with a stylized flourish at the end.

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

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/21/2025
NAME OF PROVIDER OR SUPPLIER THE ENCORE AT NORTH BRANCH		STREET ADDRESS, CITY, STATE, ZIP CODE 38610 14TH AVENUE NORTH BRANCH, MN 55056			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30608016-03 On 10/22/2025 , the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on 01/28/2025. At the time of the survey, there were 30 residents; 30 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 510}	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 510}			
{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 keep the facility in compliance with Minnesota State Fire Code. The deficient condition has 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 prob-blems are pervasive or represent a systemic	{0 775}			

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{0 775}	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on October 22, 2025, between 1:30 p.m. and 2:15 p.m. with director of mainte-nance (DM)-C, the surveyor observed the following condition: MEANS OF EGRESS: The surveyor observed a special locking system throughout the building and that there was a not lock/button/switch to unlock all the doors in the facility in the dementia care wing nor the assisted living wing. The surveyor was told by the with DM-C that the contractor was out and worked on the system. One side of the front door did not release when tested. The deficient condition was visually verified by the DM-C accompanying on the tour.	{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; (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,	{0 810}			

Minnesota Department of Health
STATE FORM 6899 ZYYQ14 If continuation sheet 4 of 10

Minnesota Department of Health

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{01060}	Continued From page 4 (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 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: Not reviewed during this survey.	{01060}			

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{01500}	Continued From page 5	{01500}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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; (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; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	{01500}			

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{01500}	Continued From page 6 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01500}			
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected	{01620}			

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{01620}	Continued From page 7 circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01620}			

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{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}			
{01910} SS=F	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: Not reviewed during this survey.	{01910}			

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{02040}	Continued From page 9	{02040}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02040}			
{02070} SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02070}			



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September 29, 2025

Licensee

The Encore at North Branch

38610 14th Avenue

North Branch, MN 55056

RE: Project Number(s) SL30608016

Dear Licensee:

On July 23, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 30, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 30, 2025 survey.

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The details of the violations noted at the time of this follow-up survey completed on July 23, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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.

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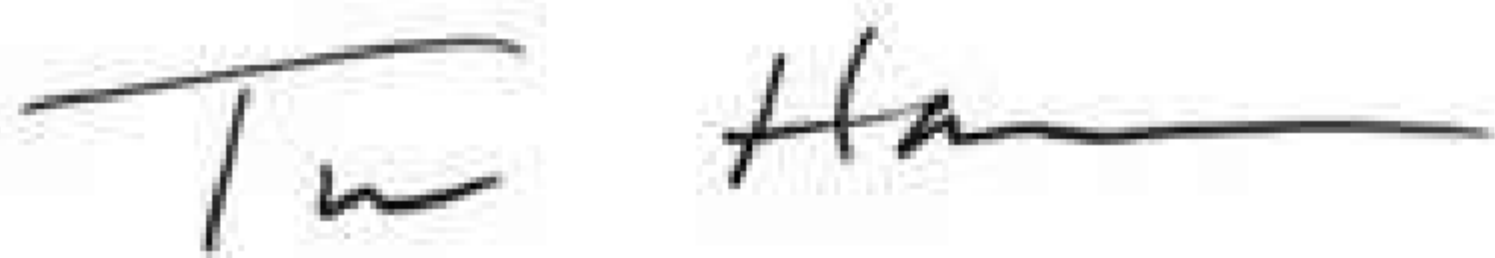
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Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30608016-02 On July 29, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 28, 2025. At the time of the survey, there were 30 residents; 30 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 510} SS=D	144G.41 Subd. 3 Infection control program	{0 510}			

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: 30608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/23/2025
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{0 510}	Continued From page 1 (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. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 510}			
{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 keep the facility in compliance with Minnesota State Fire Code. The deficient condition has the ability to affect all staff and resi-dents. 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	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 2 prob-lems 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 a facility tour on July 29, 2025, between 10:50 a.m. and 11:15 a.m. with licensed assisted living director (LALD)-A, the surveyor observed the following conditions: SMOKE DETECTOR: The surveyor observed a smoke detector missing in the mechanical/storage room be resident room 119. The wire and the electrical box were present but no smoke detector. The surveyor was told by the LALD-A that the contractor was coming back to install the smoke alarm. MEANS OF EGRESS: The surveyor observed a special locking system throughout the building and that there was a not lock/button/switch to unlock all the doors in the facility in the dementia care wing nor the assisted living wing. The surveyor was told by the LALD-A that the contractor was out and worked on the system. The front door did not release when tested. The deficient conditions were visually verified by the LALD-A accompanying on the tour.	{0 775}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}			

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{0 810}	Continued From page 3 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 810}			

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{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 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.	{01060}			

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{01060}	Continued From page 5 (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: Not reviewed during this survey.	{01060}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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; (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; (5) review of the facility's policies and procedures	{01500}			

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{01500}	Continued From page 6 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01500}			
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	{01620}			

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{01620}	Continued From page 7 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident	{01620}			

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{01620}	Continued From page 8 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01620}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}			
{01910} SS=F	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	{01910}			

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{01910}	Continued From page 9 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: Not reviewed during this survey.	{01910}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02040}			
{02070} SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care	{02070}			

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{02070}	Continued From page 10 providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02070}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 3, 2025

Licensee

The Encore at North Branch

38610 14th Avenue

North Branch, MN 55056

RE: Project Number(s) SL30608016

Dear Licensee:

On April 23, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 30, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 30, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 30, 2025, found not corrected at the time of the April 23, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on April 23, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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.

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:

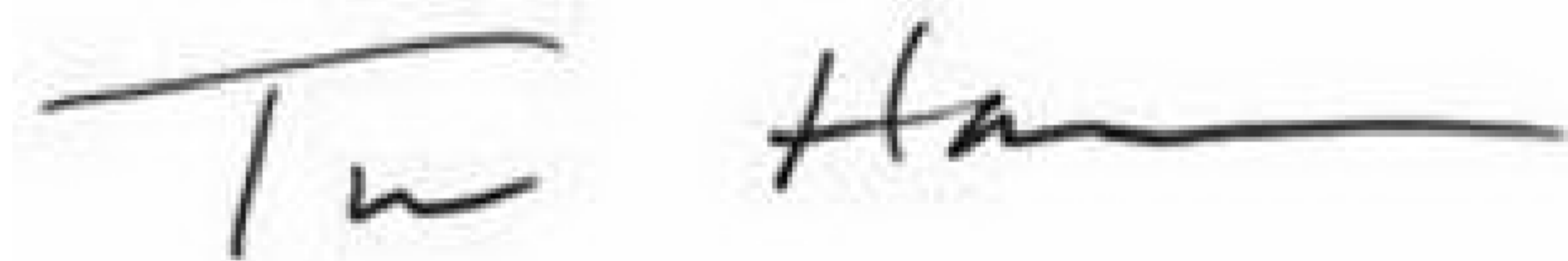
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna", with a stylized flourish at the end.

Tim Hanna, Supervisor

State Evaluation Team

Email: Tim.Hanna@state.mn.us

Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#3060816-1 On May 5, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 28, 2025. At the time of the survey, there were unknown residents; unknown receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 510}	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 510}			
{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 keep the facility in compliance with Minnesota State Fire Code. The deficient condition has 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	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on May 5, 2025, between 10:00 a.m. and 10:30 a.m. with maintenance (DM)-C, the surveyor observed the following conditions: FIRE RATED DOOR: The surveyor observed that the fire rated doors to the assisted living side of the facility were being propped open by wedges. The surveyor explained to DM-C that these doors shall be always closed unless they are held open by magnetic holds and connected to the fire alarm system so they automatically close and latch under fire alarms conditions. SMOKE ALARMS: The DM-C checked a few smoke alarms and they were over 10 years old from date of manufacture. The surveyor explained to DM-C that all smoke alarms over 10 years old from date of manufacture shall be replaced with like type alarms. EXTENSION CORD: The surveyor observed an green extension cord plugged in to the TV main gathering room. The surveyor explained to the DM-C that electrical cords shall not be routed through walls/doors and shall not be used for permanent use.	{0 775}			

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{0 775}	Continued From page 3 SMOKE DETECTOR: The surveyor observed a smoke detector missing in the mechanical/storage room be resident room 119. The wire and the electrical box were present but no smoke detector. The surveyor explained to the DM-C that the smoke detector shall be installed. The surveyor did review the fire alarm construction documents and it is on the plan. EMERGENCY/EXIT LIGHTS: The surveyor observed that a few exit/emergency lights failed to operate when push button tested. The surveyor explained to the DM-C that the exit/emergency lights shall be fixed and that all the lights shall push button tested monthly and the 30-minute test completed annually. This shall be documented. MEANS OF EGRESS: The surveyor observed a special locking system throughout the building. The surveyor explained to the DM-C that they need to work with their contractor to have them explain what type of system they have and comply with the fire code that pertains to that type of system. All these documents and further tests shall be reviewed by the Department of Health. It appears like they have a delayed egress system throughout the facility, but some doors did not operate that way. The deficient conditions were visually verified by	{0 775}			

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{0 775}	Continued From page 4 DM-C accompanying on the tour.	{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; (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	{0 810}			

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{0 810}	Continued From page 5 by: Not reviewed during this survey.	{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 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	{01060}			

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{01060}	Continued From page 6 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: Not reviewed during this survey.	{01060}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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; (4) effective approaches to use to problem solve when working with a resident's challenging	{01500}			

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{01500}	Continued From page 7 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01500}			
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}			

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{01620}	Continued From page 8 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01620}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}			

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{01880}	Continued From page 9 Not reviewed during this survey.	{01880}			
{01910} SS=F	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: Not reviewed during this survey.	{01910}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the	{02040}			

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{02040}	Continued From page 10 property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02040}			
{02070} SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02070}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 7, 2025

Licensee

The Encore At North Branch

38610 14th Avenue

North Branch, MN 55056

RE: Project Number(s) SL30608016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 30, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

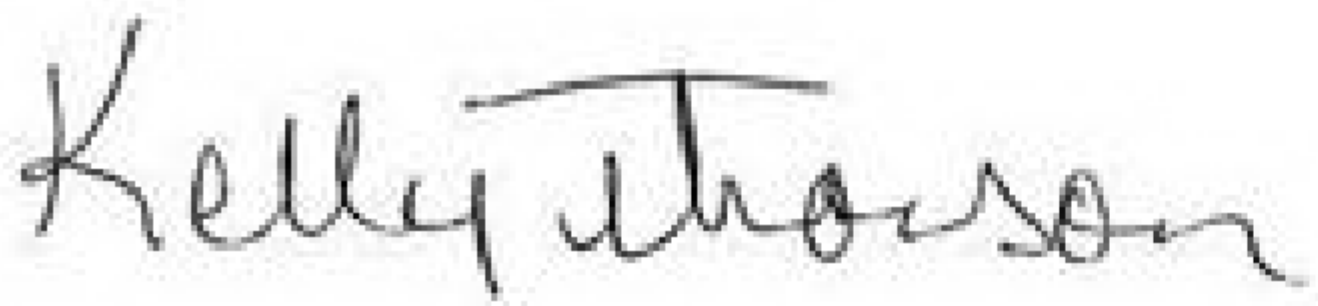
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Thorson".

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/30/2025
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30608016-0 On January 27, 2025, through January 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 28 resident(s); 28 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control related to gloving and hand hygiene for one of one unlicensed personnel (ULP)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On January 28, 2025, at 9:48 a.m., during continuous observation ULP-D without hand hygiene, prepared R9's medications. ULP-D administered R9's oral medications and without performing hand hygiene or applying gloves,	0 510			

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0 510	Continued From page 2 ULP-D administered R9's prescribed eye drops. Without performing hand hygiene, ULP-D documented R9's medications. Without performing hand hygiene ULP-D then dispensed, administered and documented R10's medications. Without performing hand hygiene ULP-D then dispensed, administered and documented R5's medications. Without performing hand hygiene ULP-D then dispensed, administered and documented R4's medications. Without performing hand hygiene ULP-D then left to complete other tasks throughout the facility. On January 28, 2025, at 10:14 a.m., ULP-D stated that hand hygiene is to be completed between residents' cares and medications. In addition, gloves are to be worn when administering insulin, creams, or eye drops. Furthermore, ULP-D stated ULP-D didn't realize they had forgotten to complete hand hygiene during observations. On January 29, 2025, at 9:49 a.m., CNS-B stated staff are trained to completed hand hygiene before starting cares or medication pass, between glove changes, and after removing gloves or completing cares. The licensee's 2.46 Infection Control policy dated December 2021 indicated reusable equipment needed to be cleaned between residents. Furthermore, hand hygiene must be performed before: contact with residents, putting on gloves and administering medications. In addition, the policy indicated hand hygiene must be completed after: contact with residents skin, contact with bodily fluid (even when gloves are worn), taking off gloves, and moving from parts of the	0 510			

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0 510	Continued From page 3 resident's body that could be contaminated to parts that are clean. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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 keep the facility in compliance with Minnesota State Fire Code. The deficient condition has 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 a facility tour on January 28, 2025, between 12:45 p.m. and 4:00 p.m. with maintenance (DM)-C and the licensed assisted living director (LALD)-A, the surveyor observed the following	0 775			

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0 775	Continued From page 4 conditions: FIRE RATED DOOR: The surveyor observed that the fire rated doors to the assisted living side of the facility were being propped open by wedges. The surveyor explained to DM-C and LALD-A that these doors shall be always closed unless they are held open by magnetic holds and connected to the fire alarm system so they automatically close and latch under fire alarms conditions. SMOKE ALARMS: The DM-C checked a few smoke alarms and they were over 10 years old from date of manufacture. The surveyor explained to DM-C and LALD-A that all smoke alarms over 10 years old from date of manufacture shall be replaced with like type alarms. EXTENSION CORD: The surveyor observed an green extension cord plugged in to the TV main gathering room. The surveyor explained to the DM-C and LALD-A that electrical cords shall not be routed through walls/doors and shall not be used for permanent use. SMOKE DETECTOR: The surveyor observed a smoke detector missing in the mechanical/storage room be resident room 119. The wire and the electrical box were present but no smoke detector.	0 775			

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0 775	Continued From page 5 The surveyor explained to the DM-C and LALD-A that the smoke detector shall be installed. The surveyor did review the fire alarm construction documents and it is on the plan. EMERGENCY/EXIT LIGHTS: The surveyor observed that a few exit/emergency lights failed to operate when push button tested. The surveyor explained to the DM-C and LALD-A that the exit/emergency lights shall be fixed and that all the lights shall push button tested monthly and the 30-minute test completed annually. This shall be documented. MEANS OF EGRESS: The surveyor observed a special locking system throughout the building. The surveyor explained to the DM-C and LALD-A that they need to work with their contractor to have them explain what type of system they have and comply with the fire code that pertains to that type of system. All these documents and further tests shall be reviewed by the Department of Health. It appears like they have a delayed egress system throughout the facility, but some doors did not operate that way. The deficient conditions were visually verified by DM-C and LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

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0 810	Continued From page 6 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and the licensee failed to document	0 810			

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0 810	Continued From page 7 required fire safety evacuation training for employees and residents. 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 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: A record review and interview were conducted on January 28, 2025, at approximately 3:15 p.m. with maintenance (DM)-C and the licensed assisted living director (LALD)-A on the fire safety and evacuation plan for the facility and training records for the employees and residents. FIRE/EVACUATION PLAN: Record review indicated the fire safety and evacuation plan shall be updated. The plan did not indicate the door locking type, how it operates and some areas where not completed. The plan was generic. TRAINING: Record review indicated the licensee failed to complete and document fire safety and evacuation training for the employees at new hire and at least twice a year thereafter and offer the residents the training at least once a year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			

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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 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.	01060			

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01060	Continued From page 9 (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 interview and record review, the licensee failed to provide written notice with required content to the resident, 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 days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 27, 2025 at 10:34 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R1 admitted to the licensee and began receiving assisted living services on December 30, 2023. R1's diagnoses included diabetes, dementia, and hypertension (HTN-high blood pressure).	01060			

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01060	Continued From page 10 R1's record lacked a written notice that contained, at a minimum: - 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 OOLTC; - 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. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On January 27, 2025, at 2:40 p.m., CNS-B stated R1 had been transported from licensee to the hospital on December 18, 2024, and an emergency relocation notice had not been provided to R1 or R1's family. Furthermore, CNS-B stated CNS-B's understanding was that informing hospice was sufficient and CNS-B was unaware that the OOLTC needed to be updated if the resident was hospitalized greater than 4 days. Additionally, CNS-B stated emergency relocation notifications had not been provided for any affected residents. The licensee's 2.97 MN [sic] Emergency Relocation policy dated December 2022, indicated that in the event of an emergency relocation, [licensee] will provide a written notice that contains, at a minimum: the reason for the	01060			

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01060	Continued From page 11 relocation, 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, if known and applicable, the approximate date or range of dates within which the resident is expected to return to the community, or a statement that a return date is not currently known, and a statement that, if the community refuses to provide housing or services after a relocation, the resident has the right to appeal. Additionally, the notice required will be delivered as soon as practicable to: the resident, legal representative, and designated representative, for residents who receive home and community-based waiver services, the resident's case manager, and the OOLTC if the resident has been relocated and has not returned to the facility within four (4) calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500			

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01500	Continued From page 12 (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; (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; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500			

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01500	Continued From page 13 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-D, ULP-E) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D was hired September 25, 2023, to provide direct cares and services to residents. ULP-E was hired January 23, 2023, to provide direct cares and services to residents. ULP-D and ULP-E's employee records lacked evidence annual training had been completed as required in the following areas: - review of providers policies and procedures, and - review of assisted living bill of rights. On January 30, 2025, at 11:15 a.m., licensed	01500			

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01500	Continued From page 14 assisted living director (LALD)-A stated the review of the providers policies and procedures, and the assisted living bill of rights was missed for all staff if not on the Relias (online education program) transcript. In addition, LALD-A stated those would be added to the annual education for all staff going forward. The licensee's 5.50 Annual Required Staff Training MN [sic] policy dated June 2021, indicated all staff will complete at least eight hours of annual training for each 12 months of employment, and would cover the above-mentioned topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620			

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01620	Continued From page 15 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for two of three 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee and began receiving assisted living services on September 1, 2020. R2's Service Plan dated October 28, 2024, indicated R2 received the following service: medication set-up.	01620			

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01620	Continued From page 16 R2's record included 90-day assessments dated November 22, 2022, and October 28, 2024, indicating 707 days had passed between assessments. R2's record lacked any assessments since October 28, 2024, indicating 94 days had passed since an assessment had been done. R3 R3 was admitted to the licensee and began receiving assisted living services on July 8, 2022. R3's Service Plan dated October 31, 2024, indicated R3 received the following service: medication management, activities of daily living (ADLs), meals with supervision, behavior management, bathing, toileting, laundry, and housekeeping. R3's record included a 90-day assessment on December 20, 2022, and March 6, 2024, indicating 442 days had passed between assessments. R3's record also contained a 90-day assessment completed on October 31, 2024, which indicated 239 days had passed since the previous assessment. On January 28, 2025, at 12:19 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was aware assessments are due every 90-days and resident assessments are behind. CNS-B further stated that CNS-B is prioritizing the completion of assessments that are behind based on if the resident has shown change in condition or decline. The licensee's 2.01 MN [sic] Assessments, Reviews & Monitoring policy dated June 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER THE ENCORE AT NORTH BRANCH		STREET ADDRESS, CITY, STATE, ZIP CODE 38610 14TH AVENUE NORTH BRANCH, MN 55056			
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01620	Continued From page 17 on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's directions. In addition, the licensee failed to monitor for expired medications in one of two medication carts and one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: STORAGE PER MANUFACTURER DIRECTION	01880			

Minnesota Department of Health

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01880	Continued From page 18 On January 28, 2025, at 2:50 p.m., the surveyor observed the medication refrigerator in the presence of ULP-D which contained medications: - 12 of R5's bisacodyl 10 milligram (mg) suppositories; - 10 of R5's acetaminophen 650 mg suppositories; - three of R6's bisacodyl 10 mg suppositories; - 18 of R6's acetaminophen 650 mg suppositories; - two of R7's bisacodyl 10 mg suppositories; and - six of R7's acetaminophen 650 mg suppositories. Manufacturers direction for bisacodyl 10 mg suppositories, last updated November 21, 2022, indicated to store at room temperature, between 59 and 86 degrees Fahrenheit (F). Manufacturers direction for acetaminophen 650 mg suppositories, last updated November 2021, indicated to store at 68 to 77 degrees F. EXPIRED MEDICATION On January 28, 2025, at 2:00 p.m., the surveyor observed the assisted living medication cart in the presence of unlicensed personnel (ULP)-E. The medication cart contained the following: - R3's open Triamcinolone (steroid cream), approximately half-full, expired February 2024; - R3's 24 pills of Senexon-S (stool softener) expired on November 16, 2024. On January 28, 2025, at 2:50 p.m., the surveyor observed the medication refrigerator in the presence of ULP-D which contained R7's unopened Latanoprost 0.005% eye drops which expired on September 12, 2024. On January 28, 2025, at 2:18 p.m., ULP-E stated	01880			

Minnesota Department of Health

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01880	Continued From page 19 the overnight staff checked the medication cart contents for expiration if there is time otherwise the licensee's clinical nurse supervisor (CNS) checked for expiration dates also. On January 28, 2025, at 3:32 p.m., clinical nurse supervisor (CNS)-B stated CNS-B audits medication storage in assisted living and memory care on alternating weeks. CNS-B further stated that CNS-B was unaware that bisacodyl and acetaminophen suppositories are not recommended to be stored in the refrigerator and CNS-B will be removed right away followed by contacting the pharmacy for advisement. The licensee's 2.42 MN [sic] Medication Storage policy dated June 2021, indicated medications will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=F	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	01910			

Minnesota Department of Health

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01910	Continued From page 20 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 interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the facility on December 20, 2023 and discharged on January 3, 2025. R1's Drug Destruction Log dated January 1, 2025, indicated CNS-B disposed of the following medications that belonged to R1: - eight tablets of Sertraline 50 milligrams (mg); - nine tablets of Sertraline 100 mg; - 12 tablets of Citalopram 10 mg; - four tablets of Chlorthalidone 25 mg;	01910			

Minnesota Department of Health

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01910	Continued From page 21 - four tablets of Atorvastatin 20 mg; - 17 tablets of Divalproex 125 mg; - four tablets of Amlodipine 5 mg; - 10 tablets of Quetiapine 25 mg; - 33 tablets of Hydrochlorothiazide (HCTZ) 25 mg; - six tablets of Trazodone 50 mg; - 11 tablets of Metoprolol Tartrate 25 mg; - nine tablets of Losartan 50 mg; - four tablets of Glipizide 5 mg; and - four tablets of Pioglitazone 30 mg. R1's Drug Destruction Log dated January 1, 2025, lacked prescription numbers for all above listed medications. On January 27, 2025, at 2:54 p.m., CNS-B stated the destruction log used for R1 is the same as is used for all residents. In addition, CNS-B stated another form that includes prescription numbers (Rx) has been used before by the previous nurse, that CNS-B is aware of the need to include Rx numbers on medication disposition records, and CNS-B will add a column to the current form to include Rx numbers going forward. The licensee's 2.07 Medication Disposal policy dated June 2021, indicated that upon disposition, the [licensee] 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Minnesota Department of Health

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02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 28, 2025, between 12:45 p.m. and 4:00 p.m. with maintenance (DM)-C and the licensed assisted living director (LALD)-A, the surveyor observed the following	02040			

Minnesota Department of Health

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02040	Continued From page 23 conditions: The surveyor observed chemicals under the bathroom sink of resident room 121. Record review the facility has not completed a (HVA) hazard vulnerability assessment completed for the facility. The deficient condition was visually verified by the LALD-A and DM-C accompanying on the tour and what is required for the HVA. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to ensure two or more persons were available 24 hours per day, seven days per week, who were responsible for meeting the scheduled and reasonably foreseeable unscheduled resident needs. This practice resulted in a level two violation (a	02070			

Minnesota Department of Health

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02070	Continued From page 24 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 held an assisted living with dementia care license for a capacity of 30 residents, with a current census of 27 residents, all of whom received assisted living with dementia care services. On January 27, 2025, at 10:50 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee staffing plan had two unlicensed personnel (ULP) working on the overnight (NOC) shift with one working in the assisted living and one in the secured memory care. LALD-A further stated the night shift hours were from 11:00 p.m., until 7:00 a.m. On January 27, 2025, at 10:51 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated if a resident fell, staff would call CNS-B with a situational update and CNS-B would assess resident need for emergency medical services (EMS). In addition, if the resident who fell resided in the assisted living (AL) and was unable to get off the floor, being assisted by one staff, CNS-B instructed staff to contact non-emergent EMS for assistance. On January 27, 2025, at 11:52 a.m., the daily staffing schedule dated January 27, 2025, indicated two staff were scheduled for NOC shift	02070			

Minnesota Department of Health

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02070	Continued From page 25 (11:00 p.m., to 7:00 a.m.). On January 27, 2025, at 12:00 p.m., LALD-A provided the licensee's undated plan of corrections (POC) from the previous survey which indicated the licensee would have minimum three ULPs scheduled for every shift. On January 28, 2025, at 9:39 a.m., ULP-D stated there were no residents in assisted living that required mechanical lift transfers. In addition, training provided to ULPs upon hire is two staff are required for all mechanical lift transfers. On January 28, 2025, at 11:07 a.m., CNS-B stated in the event a two-person transfer was required in the AL due to a fall, direction had been given to contact non-emergent EMS. On January 28, 2025, at 4:20 p.m., LALD-A stated that the licensee's POC was followed until residents who used the mechanical lifts in the AL no longer resided at the facility at which time LALD-A adjusted the staffing plan and schedule to reflect having two ULPs scheduled on the NOC shift. The licensee's 1.28 MN [sic] Staffing Plan policy, dated July 2021, indicated the licensee staffing plan is determined to ensure the ability to timely meet residents scheduled and reasonably unforeseeable unscheduled needs. In addition, the policy's Conventional Staffing Model indicated three awake ULPs are to be scheduled nightly. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02070			



Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 01/27/25
Time: 13:00:00
Report: 1025251010

Food and Beverage Establishment Inspection Report

Page 1

Location:

Encore at the Twin Cities LLC
38610 14th Avenue
North Branch, MN55056
Chisago County, 13

Establishment Info:

ID #: 0019956
Risk: High
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Encore at the Twin Cities LLC

Phone #: 6516740068
ID #: 53811

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine 24 PSI
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

Process/Item: Ambient
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

Process/Item: Ambient
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

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

New dish machine installed Dec 2024 CMA machine high temp

Discussed equipment requirements, search "MDH Equipment Specifications" for information. For specifics on equipment needing to meet requirements, see MN 4626.0506 (facility cools TCS food)

For any equipment used for potlucks, etc which does not meet the above standard, store outside of the kitchen

Type: Full
Date: 01/27/25
Time: 13:00:00
Report: 1025251010
Encore at the Twin Cities LLC

Food and Beverage Establishment Inspection Report

Page 2

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 1025251010 of 01/27/25.

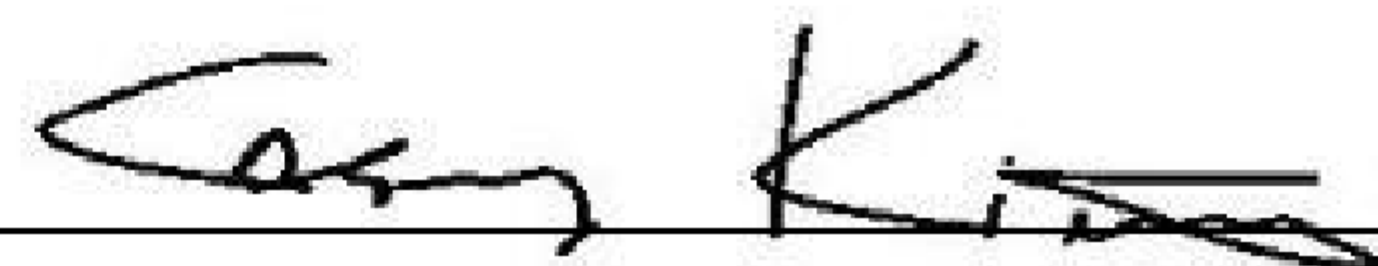
Certified Food Protection Manager Kelly P

Certification Number: 54735 Expires: 12/11/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed:  _____

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us