DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 16, 2025

Licensee
Essence Care Center
963 21st Street Southeast
Rochester, MN 55904

RE: Project Number(s) SL34623016

Dear Licensee:

On August 5, 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 November 8, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 8, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 8, 2024, found not corrected at the time of the August 5, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00

The details of the violations noted at the time of this follow-up survey completed on August 5, 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.

Also, at the time of this follow-up survey completed on August 5, 2025, we identified the following violation(s):

0250-Conditions-144g.20 Subdivision 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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.

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 Benjamin J. Zwart at 1-866-890-9290.

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,

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34623	A. BUILDING: _____ B. WING _____	R 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENCE CARE CENTER	963 21ST STREET SE ROCHESTER, MN 55904

(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 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: Project # SL34623016-3 On August 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 May 14, 2025. As a result of the follow-up survey, the following orders were reissued and a new order issued.	{0 000}		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living	0 250		

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0 250	Continued From page 1 services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category.	0 250		

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0 250	Continued From page 2 (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to cooperate with a follow-up survey. 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 August 5, 2025, at 10:10 a.m., the surveyor emailed licensed assisted living director (LALD)-A that they would be onsite at the assisted living facility today, August 5, 2025, at 10:30 a.m., for a physical environment survey follow-up. On August 5, 2025, at 10:30 a.m., the surveyor arrived onsite at the facility and rang the doorbell at the front door, there was no answer. The surveyor knocked at the front door, there was no answer. On August 5, 2025, at 10:31 a.m., the surveyor called LALD-A. During this phone interview, LALD-A stated they were sick and could not meet the surveyor onsite. LALD-A stated they would check with an employee and call the surveyor back. On August 5, 2025, at 10:34 a.m., LALD-A called the surveyor and stated in an interview they	0 250		

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0 250	Continued From page 3 would not be sending an employee onsite to meet the surveyor. On August 6, 2025, at 8:33 a.m., the surveyor emailed LALD-A and requested a copy of the current resident census and a plan of correction for the 0780 tag. Additionally, photos and/or documentation to support corrective actions completed for the 0780 tag were requested. The surveyor instructed LALD-A to email the requested information no later than 4:00 p.m. on August 6, 2025. LALD-A did not respond to the email or provide the information requested above. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 250		
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.	{0 340}		

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{0 340}	Continued From page 4 (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to take actions to comply with correction orders from a survey completed on November 8, 2024, and reissued January 23, 2025, and May 14, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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 surveys conducted on Novmber 8, 2024, January 23, 2025, and May 14, 2025, the licensee was cited using the 0780 tag identification number for a non-compliant locking mechanism on a designated emergency exit door from the egress side. On August 5, 2025, during the third follow up survey, the surveyor confirmed the deficient	{0 340}		

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{0 340}	Continued From page 5 condition remained as the licensee failed to correct obstructed egress to the exterior of the building. During a phone interview on August 5, 2025, at 10:40 a.m., licensed assisted living director (LALD)-A stated the patio door locking had not changed since the previous site visit on May 14, 2025. Previous survey 0780 tag identification number findings: On May 14, 2025, at 1:05 p.m., the surveyor toured the facility with caretaker (C)-G. During the facility tour, the surveyor observed an exit sign was posted above the dining room sliding patio door. The patio door was labeled as an exit on the posted fire evacuation floor plan. At the base of this patio door, a lock was installed in the track with a hex security screw visable. During the facility tour interview, C-G verified the above listed observations and stated the surveoyor would need to discuss this with the owner. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. Egress doors shall be openable from both sides without the use of a tool, key, or special knowledge. Any egress door in a locked facility must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. The facility did not have a fire sprinkler system or fire alarm system. The surveyor received emails on May 27, 2025, from licensed assisted living director (LALD)-A. The emails indicated the following: - "As for the patio door in the dining room, I previously explained that it must remain closed in compliance with our dementia license. The sign	{0 340}		

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{0 340}	Continued From page 6 above the door still marks it as an exit, but that has never been flagged as an issue in prior surveys. The door is locked at all times, and the key is easily accessible if needed." - "Please understand, we are not closing doors arbitrarily. We are required by law to keep certain doors closed at all times to comply with dementia care licensing standards. This is a regulatory requirement, not a facility policy. According to Minnesota Statutes §144G.81, assisted living facilities with secured dementia care units must meet specific safety requirements, including: · Doors must comply with the 2018 NFPA Life Safety Code to allow safe exit during emergencies. · An awake staff person must be present in the secured unit 24/7 to respond to resident needs. These legal requirements guide our policies, including keeping certain doors locked." - "We also want to mention that we are licensed to provide dementia care, and we are not planning to change the facility layout. The back door in question is one of two exits, and we plan to close it for safety and compliance reasons." During the first follow-up survey on January 23, 2025, at 1:00 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed an exit sign was posted above the dining room sliding patio door. The patio door was labeled as an exit on the posted fire evacuation floor plan. At the base of the patio door, a lock was installed in the track, which prevented the patio door from opening. LALD-A stated the lock had not been removed since the November 8, 2024, survey. During the facility tour interview, LALD-A stated the patio door track lock required a tool to unlock. LALD-A stated this tool was stored in the kitchen.	{0 340}		

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{0 340}	Continued From page 7 LALD-A went into the kitchen and showed the surveyor the hex wrench used for unlocking the patio door track lock. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. During the facility tour interview, LALD-A verified the patio door was kept locked and designated as an exit. Any egress door in a locked facility must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. The facility did not have a fire sprinkler system or fire alarm system. During a survey on November 8, 2024, at 10:25 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed an exit sign was posted above the dining room sliding patio door. At the base of the patio door, a lock was installed in the track which prevented the door from opening. LALD-A demonstrated this lock required a hex wrench to unlock before this door could be opened. This patio door was also labeled as an exit on the posted fire evacuation floor plan. LALD-A stated the city did not require this patio door to be designated as an emergency exit. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency.	{0 340}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;	{0 470}		

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{0 470}	Continued From page 8 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 470}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	{0 550}		

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{0 550}	Continued From page 9 for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 550}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	{0 680}		

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{0 680}	Continued From page 10 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}		

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{0 780}	Continued From page 11 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to comply with Minnesota State Fire Code, Chapter 7511. 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 the potential to affect a large portion or all of the residents). The findings include: During an interview on August 5, 2025, at 10:40 a.m., licensed assisted living director (LALD)-A stated the patio door locking and exiting plan had not changed since the previous survey on May 14, 2025. On May 14, 2025, the surveyor toured the facility with caretaker (C)-G. During the facility tour, the surveyor observed an exit sign was posted above the dining room sliding patio door. The patio door was labeled as an exit on the posted fire evacuation floor plan. At the base of this patio door, a lock was installed in the track with a hex security screw visable. During the facility tour interview, C-G verified the above listed observations and stated the surveoyor would need to discuss this with the owner. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. Egress doors shall be openable from both sides without the use of a	{0 780}		

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	34623	A. BUILDING: _____ B. WING _____	R 08/05/2025

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{0 780}	Continued From page 12 tool, key, or special knowledge. Any egress door in a locked facility must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. The facility did not have a fire sprinkler system or fire alarm system. The surveyor received emails on May 27, 2025, from licensed assisted living director (LALD)-A. The emails indicated the following: - "As for the patio door in the dining room, I previously explained that it must remain closed in compliance with our dementia license. The sign above the door still marks it as an exit, but that has never been flagged as an issue in prior surveys. The door is locked at all times, and the key is easily accessible if needed." - "Please understand, we are not closing doors arbitrarily. We are required by law to keep certain doors closed at all times to comply with dementia care licensing standards. This is a regulatory requirement, not a facility policy. According to Minnesota Statutes §144G.81, assisted living facilities with secured dementia care units must meet specific safety requirements, including: · Doors must comply with the 2018 NFPA Life Safety Code to allow safe exit during emergencies. · An awake staff person must be present in the secured unit 24/7 to respond to resident needs. These legal requirements guide our policies, including keeping certain doors locked." - "We also want to mention that we are licensed to provide dementia care, and we are not planning to change the facility layout. The back door in question is one of two exits, and we plan to close it for safety and compliance reasons."	{0 780}		

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{0 790}	Continued From page 13	{0 790}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 800}		

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{0 810}	Continued From page 14	{0 810}		
{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 by: Not reviewed during this survey.	{0 810}		

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{0 810}	Continued From page 15	{0 810}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01380}		
{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	{01500}		

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{01500}	Continued From page 16 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. 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	{01500}		

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{01500}	Continued From page 17 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}		
{01530} SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related	{01530}		

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{01530}	Continued From page 18 to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01530}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	{01650}		

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{01650}	Continued From page 19 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01650}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	{01910}		

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{01910}	Continued From page 20 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}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 25, 2025

Licensee
Essence Care Center
963 21st Street Southeast
Rochester, MN 55904

RE: Project Number(s) SL34623016

Dear Licensee:

On May 15, 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 November 8, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 8, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 8, 2024, found not corrected at the time of the May 15, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00

The details of the violations noted at the time of this follow-up survey completed on May 15, 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.

Also, at the time of this follow-up survey completed on May 15, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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 Benjamin J. Zwart at 651-201-3715.

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,

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

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{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS 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: Project # SL34623016-2 On May 14, 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 23, 2025. At the time of the survey, there was one resident; one 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 a new order issued.	{0 000}		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for	0 340		

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0 340	Continued From page 1 correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to take actions to comply with correction orders from a survey completed on November 8, 2024, and reissued January 23, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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:	0 340		

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0 340	Continued From page 2 During surveys conducted on Novmber 8, 2024, and January 23, 2025, the licensee was cited using the 0780 tag identification number for a non-compliant locking mechanism on a designated emergency exit door from the egress side. On May 14, 2025, during the second follow up survey, the surveyor confirmed the deficient condition remained, the licensee failed to provide unobstructed egress to the exterior of the building. Previous survey 0780 tag identification number findings: During the first follow-up survey on January 23, 2025, at 1:00 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed an exit sign was posted above the dining room sliding patio door. The patio door was labeled as an exit on the posted fire evacuation floor plan. At the base of the patio door, a lock was installed in the track, which prevented the patio door from opening. LALD-A stated the lock had not been removed since the November 8, 2024, survey. During the facility tour interview, LALD-A stated the patio door track lock required a tool to unlock. LALD-A stated this tool was stored in the kitchen. LALD-A went into the kitchen and showed the surveyor the hex wrench used for unlocking the patio door track lock. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. During the facility tour interview, LALD-A verified the patio door was kept locked and designated as an exit. Any egress door in a locked facility must interconnect with the fire safety systems and must default to an	0 340		

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0 340	Continued From page 3 unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. The facility did not have a fire sprinkler system or fire alarm. During a survey on November 8, 2024, at 10:25 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed an exit sign was posted above the dining room sliding patio door. At the base of the patio door, a lock was installed in the track which prevented the door from opening. LALD-A demonstrated this lock required a hex wrench to unlock before this door could be opened. This patio door was also labeled as an exit on the posted fire evacuation floor plan. LALD-A stated the city did not require this patio door to be designated as an emergency exit. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies	{0 470}		

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{0 470}	Continued From page 4 and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 470}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility	{0 550}		

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{0 550}	Continued From page 5 Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 550}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}		

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{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code, Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 780}		

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{0 780}	Continued From page 7 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: On May 14, 2025, at 1:05 p.m., the surveyor toured the facility with caretaker (C)-G. During the facility tour, the surveyor observed an exit sign was posted above the dining room sliding patio door. The patio door was labeled as an exit on the posted fire evacuation floor plan. At the base of this patio door, a lock was installed in the track with a hex security screw visable. During the facility tour interview, C-G verified the above listed observations and stated the surveoyor would need to discuss this with the owner. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. Egress doors shall be openable from both sides without the use of a tool, key, or special knowledge. Any egress door in a locked facility must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. The facility did not have a fire sprinkler system or fire alarm system. The surveyor received emails on May 27, 2025, from licensed assisted living director (LALD)-A. The emails indicated the following: - "As for the patio door in the dining room, I previously explained that it must remain closed in compliance with our dementia license. The sign above the door still marks it as an exit, but that has never been flagged as an issue in prior	{0 780}		

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{0 780}	Continued From page 8 surveys. The door is locked at all times, and the key is easily accessible if needed." - "Please understand, we are not closing doors arbitrarily. We are required by law to keep certain doors closed at all times to comply with dementia care licensing standards. This is a regulatory requirement, not a facility policy. According to Minnesota Statutes §144G.81, assisted living facilities with secured dementia care units must meet specific safety requirements, including: · Doors must comply with the 2018 NFPA Life Safety Code to allow safe exit during emergencies. · An awake staff person must be present in the secured unit 24/7 to respond to resident needs. These legal requirements guide our policies, including keeping certain doors locked." - "We also want to mention that we are licensed to provide dementia care, and we are not planning to change the facility layout. The back door in question is one of two exits, and we plan to close it for safety and compliance reasons."	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	{0 790}		

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{0 790}	Continued From page 9 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 800}		
{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	{0 810}		

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{0 810}	Continued From page 10 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}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident;	{01380}		

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{01380}	Continued From page 11 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01380}		
{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	{01500}		

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{01500}	Continued From page 12 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}		
{01530} SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and	{01530}		

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{01530}	Continued From page 13 de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	{01530}		

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{01530}	Continued From page 14 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01530}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01650}		

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{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: 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	{02040}		

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{02040}	Continued From page 16 (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}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 27, 2025

Licensee
Essence Care Center
963 21st Street Southeast
Rochester, MN 55904

RE: Project Number(s) SL34623016

Dear Licensee:

On January 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 November 8, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 8, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 8, 2024, found not corrected at the time of the January 23, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00

The details of the violations noted at the time of this follow-up survey completed on January 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 Benjamin J. Zwart at 651-201-3715.

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,

Benjamin J. Zwart, Supervisor
State Evaluation Team
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34623	A. BUILDING: _____ B. WING _____	R 01/23/2025

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{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS 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: On January 23, 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 November 8, 2024. At the time of the survey, there was one resident; one receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	{0 470}		

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{0 470}	Continued From page 1 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 470}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of	{0 550}		

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{0 550}	Continued From page 2 Health. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 550}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}		

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{0 780}	Continued From page 3	{0 780}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code, Chapter 7511 and provide an interconnected smoke alarm. 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	{0 780}		

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{0 780}	Continued From page 4 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: On January 23, 2025, at 1:00 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. An exit sign was posted above the dining room sliding patio door. The patio door was labeled as an exit on the posted fire evacuation floor plan. At the base of the patio door, a lock was installed in the track, which prevented the patio door from opening. LALD-A stated the lock had not been removed since the November 8, 2024, survey. During the facility tour interview, LALD-A stated the patio door track lock required a tool to unlock. LALD-A stated this tool was stored in the kitchen. LALD-A went into the kitchen and showed the surveyor the hex wrench used for unlocking the patio door track lock. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. During the facility tour interview, LALD-A verified the patio door was kept locked and designated as an exit. Any egress door in a locked facility must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. The facility did not have a fire sprinkler system or fire alarm system. 2. The surveyor requested that LALD-A test the smoke alarm in the basement outside the bedrooms for interconnection with the other dwelling unit smoke alarms. During the facility	{0 780}		

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{0 780}	Continued From page 5 tour interview, LALD-A stated the smoke alarm interconnection had not been completed yet as it required a permit from the city. The company hired to fix the smoke alarm interconnection was scheduled to be onsite next week.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	{0 800}		

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{0 800}	Continued From page 6 by: Not reviewed during this survey.	{0 800}		
{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.	{0 810}		

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{0 810}	Continued From page 7 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 810}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01380}		
{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	{01500}		

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{01500}	Continued From page 8 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. 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	{01500}		

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{01500}	Continued From page 9 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}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	{01530}		

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{01530}	Continued From page 10 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01530}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	{01650}		

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{01650}	Continued From page 11 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01650}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: 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	{02040}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENCE CARE CENTER	963 21ST STREET SE ROCHESTER, MN 55904

(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
{02040}	Continued From page 12 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: Not reviewed during this survey.	{02040}		

Electronically Delivered

December 16, 2024

Licensee
Essence Care Center
963 21st Street Southeast
Rochester, MN 55904

RE: Project Number(s) SL34623016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 8, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: -866-890-9290

HHH

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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: SL34623016-0 On November 4, 2024, through November 8, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one resident; one 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 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 and assisted living license with dementia care license and was licensed for a capacity of four residents with a current census of one resident. On November 4, 2024, at 10:15 a.m. during entrance conference, the facility staffing plan was requested. Clinical nurse supervisor (CNS)-B stated she had not created a staffing plan; and was not aware of the requirement to review the plan two times annually. During the facility tour at 11:30 a.m. with CNS-B, a staffing plan was noted to be posted on a bulletin board in the living room area of the facility. The staffing plan was undated and lacked a signature or an indication that the registered nurse had reviewed it twice each year. CNS-B stated she forgot the staffing plan was created; however, she had not reviewed it as required. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		

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0 550	Continued From page 3	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required complaint and grievance information to include the contact information for the facility representative who managed the facility's grievances. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 4 The findings include: On November 4, 2024, at 11:30 a.m. during a facility review of postings, the surveyor noted various postings on two bulletin boards on the upper level of the facility. One bulletin board included the facility's Grievance Policy and Procedure; however, the policy and procedure lacked the required information about the facility's grievance procedure to include the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. On November 4, 2024, at 1:20 p.m. licensed assisted living director (LALD)-A stated he didn't realize the posting was missing the contact information for him as the facility representative who managed grievances and complaints; but would update with the required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 5 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements and failed to post the plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 4, 2024, at 10:20 a.m. during the	0 680		

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0 680	Continued From page 6 entrance conference, the licensee's emergency preparedness plan and Appendix Z was discussed. Clinical nurse supervisor (CNS)-B stated licensed assisted living director (LALD)-A managed the maintenance of the emergency preparedness plan. During a tour of the facility on November 4, 2024, at 12:00 p.m., the surveyor asked where the facility Emergency Preparedness Plan (EPP) was kept. CNS-B stated the plan was currently at the offsite office and not in the facility. On November 5, 2024, at 12:00 p.m. LALD-A provided the surveyor with the facility's two EP binders. On November 6, 2024, at 10:30 a.m., the surveyor and LALD-A met to review the content of the facility's EP plan and review the required content of Appendix Z. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - the licensee established/maintain a comprehensive emergency plan (EP) dated August 1, 2022, which described the facility's approach to meeting health/safety/security needs of staff/residents addressing how they would coordinate with other, health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.) ; however the licensee failed to review/update the plan annually as required. - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious	0 680		

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0 680	Continued From page 7 diseases (EIDs) and document risk assessment for an all hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community based risks (evacuation plans, staffing surges/shortages, back-up plans); the risk assessment was signed and dated but was not completed; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional, and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate	0 680		

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0 680	Continued From page 8 means of communication with facility staff and Federal, State, tribal, regional, and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to aid, to the authority having jurisdiction, the incident command center, or designee; and - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise; and - review of the missing resident policy/procedure quarterly On November 6, 2024, at 11:15 a.m., LALD-A stated he felt he had the required content of Appendix Z in place, but he could not find the content and stated it was not in the binders provided to the surveyor.	0 680		

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0 680	Continued From page 9 The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2022, indicated the licensee would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code, Chapter 7511 and provide interconnected smoke alarms. 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 the potential to affect a large portion or all of the residents). The findings include: On November 8, 2024, at 10:25 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. An exit sign was posted above the dining room sliding patio door. At the base of the patio door, a lock was installed in the track which prevented the door from opening. LALD-A demonstrated this lock required a hex wrench to unlock before this door could be opened. This patio door was also labeled as an exit on the posted fire evacuation floor plan. LALD-A stated the city did not require this patio door to be designated as an emergency exit. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. 2. When LALD-A tested the smoke alarms installed outside the bedrooms in the basement	0 780		

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0 780	Continued From page 11 and on the main floor, none of the other smoke alarms in the dwelling unit were actuated. 3. When LALD-A tested the smoke alarms installed in bedrooms 1 and 2, none of the other smoke alarms in the dwelling unit were actuated. The dwelling unit smoke alarms were not interconnected as required by statute. During the facility tour interview on November 8, 2024, LALD-A verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.	0 790		

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ESSENCE CARE CENTER	963 21ST STREET SE ROCHESTER, MN 55904

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0 790	Continued From page 12 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: On November 8, 2024, at 10:25 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. Monthly inspections had not been recorded on the back of the tag attached to the portable fire extinguisher mounted in the dining room. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. 2. There was an empty bracket for a portable fire extinguisher on the wall adjacent to the back door in the basement. A fire extinguisher sign was posted next to the bracket. The location of all portable fire extinguishers must be accurately identified in the facility. During the facility tour interview on November 8, 2024, LALD-A verified the above listed fire extinguisher observations. LALD-A stated a fire extinguisher was not needed in the basement and had been removed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the 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 the potential to affect a large portion or all of the residents). The findings include: On November 8, 2024, at 10:25 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. Tape was installed between the basement back door and the door frame. LALD-A stated during the tour that the door seal had been replaced but it was still leaking cold air into the home.	0 800		

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0 800	Continued From page 14 2. A cover was not installed on one electrical wall outlet in the mechanical room. 3. The door for unoccupied resident room 4 could not be opened fully as the door was obstructed by furniture stored inside this room. 4. Bifold closet door panels were off the track in unoccupied resident rooms 3 and 4. 5. One light cover was missing in the main floor resident bathroom. 6. The exterior electrical outlet was cracked and a weatherproof protective cover not installed over the outlet on the back deck. 7. Three balusters were missing from the deck railing. 8. Several sections of exterior siding near the base of the home were deteriorated. During the facility tour interview on November 8, 2024, LALD-A verified the above listed physical environment observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 15 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop the fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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).	0 810		

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0 810	Continued From page 16 The findings include: On November 8, 2024, at 10:25 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, LALD-A verbally identified resident sleeping rooms as 1, 2, 3, and 4. The surveyor observed resident sleeping rooms were not identified by numbers posted on or adjacent to the sleeping room doors. Resident sleeping rooms are required to be identified and correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview, LALD-A verified the above listed observations. On November 8, 2024, at 11:15 a.m., the surveyor requested records for employee FSEP training and resident training on fire safety and evacuation from LALD-A. LALD-A explained these records were not available onsite and this information would be emailed to the surveyor by the end of the day. On November 8, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to include the following: The location and number of resident sleeping rooms evident by the lack of an accurate facility diagram in the emergency preparedness manual binder. A floor plan for the basement was not included. On November 8, 2024, at 10:25 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and two resident sleeping rooms were observed in the basement.	0 810		

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0 810	Continued From page 17 The FSEP Fire Safety Policy dated August 1, 2021, was a template from a third-party provider and had not been developed for use at this facility. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym.The FSEP inaccurately referenced pull fire alarms, which were not observed on the facility tour. The FSEP failed to identify specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures for residents were included. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. During an interview on November 8, 2024, at 11:50 a.m., LALD-A verified the FSEP required revision. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by the lack of training documentation. One employee training record for	0 810		

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0 810	Continued From page 18 fire safety dated August 1, 2024, was provided. No additional training records were provided to support the FSEP training frequency had been met. Record review of the available documentation indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. No resident training records were provided for review. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill logs lacking the required frequency and documentation. One fire drill was recorded in 2024, dated September 14, 2024. One fire drill was recorded in 2023, dated August 12, 2023. One fire drill was recorded in 2022, dated August 14, 2022. Two fire drills were recorded in 2021, dated August 31, 2021, and September 14, 2021. The time or shift of the fire drills were not recorded on any of the logs. During an interview on November 8, 2024, at 11:50 a.m., LALD-A verified the evacuation drill frequency was not met and the required information not recorded. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380		

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01380	Continued From page 19 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competency training and evaluations were completed by one of two unlicensed personnel (ULP-C) prior to providing direct cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a hire date of September 7, 2024, and provided direct care services under the licensee's assisted living with dementia care license.	01380		

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01380	Continued From page 20 On November 5, 2024, at 7:05 a.m., ULP-C was observed to set up and administer R1's medications and complete a blood sugar check. ULP-C's Educare training record printed November 5, 2024, lacked evidence of the following required training topics prior to providing services: - documentation requirements for all services; and - reports of changes in the resident's condition to the supervisor designated by the assisted living provider On November 6, 2024, at 10:30 a.m. clinical nurse supervisor (CNS)-B stated she assigned the ULP their Educare training courses at the time of hire and missed assigning this training course to cover the required training as listed above for ULP-C. The licensee's Competency Training Evaluations policy dated August 1, 2022, indicated home health aides (HHA) providing assisted living services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process: HHA may not work for the licensee until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: - documentation requirements for all services; and - reports of changes in the resident's condition to the supervisor designated by the assisted living provider No further information provided.	01380		

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01380	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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	01500		

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01500	Continued From page 22 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: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01500		

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01500	Continued From page 23 The findings include: CNS-B was hired on January 1, 2010, as the registered nurse and to provide direct care services to the licensee's residents. On November 4, 2024, at 10:05 a.m. CNS-B was observed to interact in the dining room area with R1. On November 4, 2024, at 12:30 p.m. CNS-B's Educare (the licensee's online training system) transcript dated November 4, 2024, was provided. The training transcript indicated the last annual training was completed on September 22, 2023. CNS-B's record lacked the required eight hours of annual training due September 2024; furthermore, the record lacked the required annual training content to include: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - 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; - 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	01500		

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01500	Continued From page 24 disease, or related disorders; - 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 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On November 4, 2024, at 2:10 p.m. CNS-B stated licensed assisted living director (LALD)-A assigned her annual training on Educare and had not yet completed this. She stated she should have completed her required annual training topics to include the content and required eight hours by September 2024. Furthermore, CNS-B stated she was not sure how the licensee was capturing the annual review of the licensee's policies and procedures as required. On November 6, 2024, at 10:30 a.m. licensed assisted living director (LALD)-A stated the licensee had staff review the licensee's policies and procedures online; however, he had not developed a way to track the training/review of policies to show compliance with the training requirement for any staff. The licensee's Annual Required Staff training dated August 1, 2021, indicated annual training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The following training elements MUST be included every 12 months to all staff who performs direct care services: 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	01500		

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01500	Continued From page 25 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 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics	01530		

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01530	Continued From page 26 related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (clinical nurse supervisor (CNS)-B) received the required dementia care training. 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: CNS-B was hired on January 1, 2010, as the	01530		

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	34623	A. BUILDING: _____ B. WING _____	11/08/2024

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01530	Continued From page 27 registered nurse and to provide direct care services to residents of the facility. On November 4, 2024, at 10:05 a.m. CNS-B was observed to interact in the dining room area with R1. CNS-B's Educare (online training platform) training transcript printed on November 4, 2024, indicated CNS-B received the required (eight) dementia training hours and topics in 2022, and the required minimum two hours of dementia training was completed by September 9, 2023; however, her record lacked evidence of two hours of dementia training was completed by September 2024. On November 4, 2024, at 2:10 p.m. CNS-B stated licensed assisted living director (LALD)-A assigned her Educare training each year but had not yet assigned the training, and further stated "I should have completed the required two hours of dementia training by September 2024." The licensee's Dementia Care Training policy dated August 1, 2022, indicated for facilities with an assisted living with dementia care license must ensure: -direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date. -all staff will complete two (2) hours of additional training for each 12 months of work thereafter No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		

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01650	Continued From page 28	01650		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01650		

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01650	Continued From page 29 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the Assisted Living with Dementia Care facility on November 7, 2021, to receive direct care services with diagnoses including type 2 diabetes, history of stroke with unspecified dementia. On November 5, 2024, at 7:05 a.m. unlicensed personnel (ULP)-C was observed to administer R1's medications and complete a blood sugar check. R1's Service Plan dated June 3, 2024, included medication administration, blood sugar testing, behavior management, and stand by assistance with bathing. R1's Service Plan included a page labeled Exhibit 3, Schedule of Fees. The page was signed by R1 and a facility representative; however, the document was otherwise blank and lacked the required content of fees for the services he was receiving. Furthermore, R1's Service Plan included the required designated line for a contingency plan that included the action to be taken if the scheduled service could not be provided; however, the line was blank/not completed. On November 5, 2024, at 11:30 a.m. licensed assisted living director (LALD)-A stated R1's	01650		

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01650	Continued From page 30 services were covered by a waiver; however, he did pay rent separately and neither of these fees were indicated on Exhibit 3 of the Service Plan and needed to be updated. The licensee's Service Plan policy dated August 1, 2023, indicated the service plan would include: - The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; and - a contingency plan that included actions [licensee name] will take if scheduled services could not be provided No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable,	01910		

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01910	Continued From page 31 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 the disposition of the medication including the required content for one of one discharged resident (R2). 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: R2's record indicated he began receiving assisted living with dementia care services on November 5, 2021, and was discharged on May 1, 2024. R2's Service Plan was requested but was not received. R2's Medication Administration Record (MAR) was requested, but not received. R2's signed discharge orders dated August 31, 2024, indicated R2 received medication administration and included a list of R2's medications at the time of his discharge. R2's Discharge Summary dated May 2, 2024,	01910		

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01910	Continued From page 32 indicated R2 discharged to a local group home provider. The Discharge Summary indicated medications at discharge were given to a group home employee. R2's Current Medications at Discharge document printed on November 4, 2024, listed R2's medications, dosages, and prescription numbers; however, the record lacked the quantity of each medication given to the group home staff; and lacked the required signatures by the licensee and by the group home staff who received the medications. On November 5, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated R2's discharge was very disorganized; she stated the licensee provided a great deal of discharge information to the receiving group home in advance; the group home staff arrived at the licensee's facility without notice and loaded up R2's belongings and medications without the licensee's nurse or director being present. The licensee's unlicensed personnel on duty were not aware of the proper procedure for the release of R2's medications. The licensee's Medication Disposal policy dated August 1, 2021, indicated 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. 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	01910		

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01910	Continued From page 33 individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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 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 conduct a physical environment hazard vulnerability or safety risk assessment on and around the facility property with mitigation factors. 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 the potential to affect a large portion or all	02040		

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02040	Continued From page 34 residents). The findings include: A copy of the Hazard Vulnerability Assessment with a preparation date of August 1, 2021, and reviewed date of August 1, 2024, was emailed to the surveyor. This assessment tool listed global issues such as fire, bomb threat, pandemic, and civil disturbance as hazards with no mitigation of these hazards listed. Physical environment hazards to the dementia care residents that were site, building, and population-specific were not identified in the assessment with mitigation factors to protect dementia resident from harm. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Food and Beverage Establishment Inspection Report

Type: Full
Date: *11/05/24*
Time: 11:37:37
Report: 1038241199

Location:
Robland Home Health Care
963 21st Street Se
Rochester, MN55904
Olmsted County, 55

Establishment Info:
ID #: 0038367
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072524619
ID #:

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

No NEW orders were issued during this inspection.

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

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 1038241199 of 11/05/24.

Certified Food Protection Manager: Omar hassan

Certification Number: FM108411 Expires: 09/12/27

Signed: _____
Establishment Representative

Signed: _____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us