DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 31, 2025

Licensee
Risen Home Care LLC
3012 Thurber Road
Brooklyn Center, MN 55429

RE: Project Number(s) SL35306015

Dear Licensee:

On November 27, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 21, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

September 30, 2024

Licensee
Risen Home Care LLC
3012 Thurber Road
Brooklyn Center, MN 55429

RE: Project Number(s) SL35306015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 21, 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.

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

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

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,

Renee L. Anderson

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35306	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN HOME CARE LLC	3012 THURBER ROAD BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35306015-0 On August 18, 2024, through August 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 4 residents; 4 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 780 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:	0 780		

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0 780	Continued From page 2 (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 provide smoke alarms that complied with fire protection requirements. 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 August 21, 2024, at 10:30 a.m., survey staff	0 780		

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0 780	Continued From page 3 toured the facility with licensed assisted living director (LALD)-A. During the tour, LALD-A tested smoke alarms in resident bedrooms and outside the sleeping areas. The surveyor observed when the smoke alarm in bedroom 1 was tested, it did not actuate the smoke alarm in bedroom 2 and the smoke alarms installed in the basement. During the facility tour interview on August 21, 2024, LALD-A verified the dwelling unit smoke alarms were not interconnected, as required by statute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 800		

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0 800	Continued From page 4 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 August 21, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: - Screen hardware obstructed the egress windows in resident bedrooms 2 and 3. - A gas grill with an attached propane tank was stored in the 3-season porch. - An exit sign was improperly posted above the door leading from the home into the attached garage. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. - Hardware for a sliding chain lock was installed on the front door. - There was a gap at the top of the bedroom door for occupied resident room 5. During the facility tour interview on August 21, 2024, LALD-A verified the above listed observations while accompanying on the tour. 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:	0 810		

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0 810	Continued From page 5 (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 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, interview, and record review, the licensee failed to develop a 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.	0 810		

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0 810	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 21, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A During the tour, the surveyor observed the following: - Fire safety and evacuation floor plans were not posted. - LALD-A verbally identified resident sleeping rooms as 4 and 5 in the basement. Survey staff observed room numbers were not posted on or adjacent to the door for these resident sleeping rooms. Resident sleeping rooms must be identified and are required to correspond with the labels on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview on August 21, 2024, LALD-A verified the resident sleeping rooms in the basement were not properly identified. On August 21, 2024, LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to include specific fire protection procedures necessary for residents evident by the lack of these procedures in the plan.	0 810		

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0 810	Continued From page 7 One resident was identified as requiring assistance during an evacuation. The licensee failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents in the FSEP. The FSEP inappropriately referenced pull fire alarms, which were not installed at this facility. During an interview on August 21, 2024, at 11:45 a.m., LALD-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by the lack of training documentation. An annual policy and rules review record dated July 18, 2024, for employee training on the facility FSEP was provided. No additional training records were provided to support employee FSEP training had been completed in the last year. During an interview on August 21, 2024, at 11:45 a.m., LALD-A verified FSEP training had not been completed with employees at the frequency required by statute. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill logs lacking the required frequency. Four fire drills were recorded in 2024, dated April, June, July, and August. No evacuation drills were recorded in 2024 during January, February, and March. During an interview on August 21, 2024, at 11:45 a.m., LALD-A verified the evacuation drill frequency of every other month was not met.	0 810		

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0 810	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and all staff. 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:	0 820		

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0 820	Continued From page 9 On August 21, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. The egress windows in resident bedrooms were opened by LALD-A. Survey staff measured the clear open area of the windows. The window in bedroom 1 did not meet the minimum requirements for safe egress. Egress window: Unoccupied resident bedroom 1 - the clear open area of the egress window measured 18.5 inches width, 37 inches height, with a total clear area of 684.5 square inches, and was obstructed by the window opening hardware. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). Window hardware must not obstruct the total clear area of the egress window. During the facility tour interview on August 21, 2024, LALD-A verified the egress window measurements and the window hardware obstruction. Smoking materials disposal: Burnt cigarettes were disposed of on the floor surface of the wooden deck at the back of the home. In the backyard adjacent to the wooden deck, burnt cigarettes were disposed of inside a plastic bucket containing water. Improper disposal of smoking materials creates a fire hazard. During the facility tour interview on August 21, 2024, LALD-A verified the improper disposal of smoking materials by residents.	0 820		

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0 820	Continued From page 10 TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 950		

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0 950	Continued From page 11 licensee failed to identify a designated representative or document that the resident declined to designate a representative for one of one residents (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's service plan, dated February 21, 2022, indicated R1 received services, including assistance with activities of daily living (ADLs), housekeeping, and medication management. R1's contract, dated August 1, 2021, lacked documentation that R1 was given the opportunity to designate a representative and the required verbiage: "Right to designate a representative for certain purposes. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." During an interview on August 20, 2024, at 10:20	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35306	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN HOME CARE LLC	3012 THURBER ROAD BROOKLYN CENTER, MN 55429

(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
0 950	Continued From page 12 a.m., licensed assisted living director (LALD)-A stated the contract was the same for all residents and required verbiage was missing from all residents' contracts. She further stated that she was not aware that the designated representative verbiage was required in the contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35306	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN HOME CARE LLC	3012 THURBER ROAD BROOKLYN CENTER, MN 55429

(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
01640	Continued From page 13 by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted August 20, 2020, and had diagnoses to include schizophrenia, and type II diabetes. R1's service plan, dated February 21, 2022, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. The service plan indicated that R1 received blood glucose checks four times a day. On August 20, 2024, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with checking blood sugar. R1's record lacked an updated service plan to reflect the current services provided, including checking blood sugars daily. R1's providers orders, dated February 21, 2023, indicated the frequency of blood sugar testing	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35306	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN HOME CARE LLC	3012 THURBER ROAD BROOKLYN CENTER, MN 55429

(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
01640	Continued From page 14 changed to one time daily. On August 20, 2024, at 11:30 a.m., the clinical nurse supervisor (CNS)-B stated that she was not aware the service plan had not been updated to reflect the change in blood sugar checks from four times a day to once a day. She further stated the resident had not signed a updated service plan with the changes. The licensee's Service Plan policy, undated, indicated the service plan would include, "Changes in types of services or charges will be based on assessment of the client or client preferences, and reviewed with the client/responsible party and noted on the Service Plan, as appropriate. All changes in the Service Plan must be acknowledged by the client/responsible party." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35306	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN HOME CARE LLC	3012 THURBER ROAD BROOKLYN CENTER, MN 55429

(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
01970	Continued From page 15 Based on observation, interview, and record review, the licensee failed to obtain updated prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan, dated February 21, 2022, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. The service plan indicated that R1 received blood glucose checks four times a day. R1's providers orders, dated February 21, 2023, indicated blood glucose checks daily. On August 20, 2024, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with checking blood sugar. R1's record lacked updated orders for the blood glucose treatment within the last twelve months. On August 20, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated that she was not aware that treatment orders needed to be updated every twelve months if the orders	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35306	A. BUILDING: _____ B. WING _____	08/21/2024

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01970	Continued From page 16 remained unchanged. The licensee's Treatment and Therapy Mahagement Plan policy, undated, indicated, "Treatment and therapy orders must be renewed at least every 12 months." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *08/20/24*
Time: 17:03:57
Report: 1018241119

Food and Beverage Establishment Inspection Report

Location:
Risen Home Care Llc
3012 Thurber Road
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0039416
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632278846
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

ESTABLISHMENT COULD NOT PRODUCE AN ILLNESS LOG DURING THE INSPECTION. DISCUSSED ILLNESS REPORTING AND ILLNESS LOG USE WITH MANAGER. ILLNESS LOG SENT WITH REPORT.

Comply By: 08/20/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. CORRECTED ON SITE.

Comply By: 08/20/24

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

EMPLOYEE STATED THAT DISHWASHER WAS ONLY USED FOR DRYING DISHES AND ALL OTHER DISHES WERE WASHED BY HAND. NO SANITIZING WAS TAKING PLACE. DISCUSSED WITH MANAGER TO CLEAN AND SANITIZE DISHES IN THE DISHWASHER FROM NOW ON.

Comply By: 08/20/24

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

ESTABLISHMENT WAS NOT ABLE TO PRODUCE A FOOD THERMOMETER AT THE TIME OF INSPECTION. COMPLY WITH RULE.

Comply By: 08/20/24

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

INSPECTION CONDUCTED WITH ANGEL WOEHLER (MDH) PRESENT

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT, RESIDENTIAL CABINETS/COUNTER TOPS, AND RESIDENTIAL STYLE FLOORS, WALLS AND CEILINGS. ALL APPEAR TO BE IN GOOD CONDITION.

ESTABLISHMENT HAS A DISHWASHER THAT HAS A SANITIZE FUNCTION AVAILABLE FOR DISHES.

SINK HAS TWO COMPARTMENTS THAT ARE DESIGNATED ONE FOR HAND WASHING AND ONE FOR RINSING DISHES.

ESTABLISHMENT DOES ALL SAME DAY FOOD SERVICE FOR CLIENTS, AND NO LEFTOVERS ARE SAVED.

DISCUSSED EMPLOYEE ILLNESS REPORTING AND ILLNESS LOGS.

DISCUSSED PEST CONTROL MANAGEMENT.

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

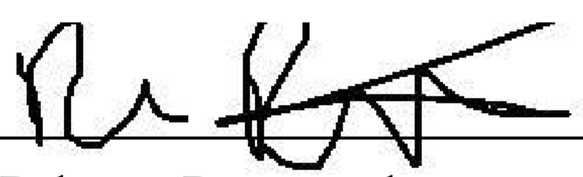
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018241119 of 08/20/24.

Certified Food Protection Manager: ANGELIQUE B KAPILA

Certification Number: FM109780 Expires: 02/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
ANGELIQUE B KAPILA
MANAGER

Signed: 

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us