



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 14, 2025

Licensee

Risen Home Care LLC

5333 James Avenue

Brooklyn Center, MN 55430

RE: License Number 418928

Health Facility Identification Number (HFID) 36999

Project Number(s) SL36999015

Dear Licensee:

On January 13, 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 July 11, 2025, and follow-up survey completed on September 05, 2025. This follow-up survey found the facility to be in compliance. Based on these findings, the condition(s) on the license were removed effective January 13, 2025.

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

Sincerely,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 15, 2024

Licensee

Risen Home Care LLC

5333 James Avenue

Brooklyn Center, MN 55430

RE: Conditional License Number 415046
Health Facility Identification Number (HFID) 36999
Project Number(s) SL36999015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on September 5, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **January 13, 2025**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,000.00. **MDH is not imposing these fines against your license at this time.**

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 13, 2024, found not corrected at the time of the September 5, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has

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

To submit a hearing request, please visit:

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

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Risen Home Care LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Risen Home Care LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **Health Facility Construction Permit:** Risen Home Care LLC, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Risen Home Care LLC, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.
- b. **General Contractor:** Risen Home Care LLC, must provide the following to Tim Hanna (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:
 - i. Name
 - ii. License Number
 - iii. Contact Information
- c. **Egress Window Requirements:** Risen Home Care LLC, will replace at least one window in occupied resident sleeping room #2 meeting the minimum size requirements.

- i. Must have a minimum openable width of no less than 20 inches
- ii. Must have a minimum openable height of no less than 20 inches
- iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
- iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
- v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Risen Home Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Risen Home Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Risen Home Care LLC's assisted living facility license, and Risen Home Care LLC will correct any outstanding violations identified during the survey. If Risen Home Care LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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 Casey DeVries directly at: 651-201-5917.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36999	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/05/2024
NAME OF PROVIDER OR SUPPLIER RISEN HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5333 JAMES AVENUE BROOKLYN CENTER, MN 55430			
(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: SL36999015-0 On September 4, 2024, through September 5, 2024, the Minnesota Department of Health conducted an Assisted Living license follow up survey at the above provider pursuant to a survey completed on July 11, 2024, and the following correction orders are reissued. At the time of the survey, there were four residents, all four receiving services under the Assisted Living license. Immediate correction order was identified and reissued on September 4, 2024, issued for SL36999015-1, tag 0820. On September 9, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 820}	Continued From page 1	{0 820}			
{0 820} SS=G	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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This effected the occupied resident (R5) in bedroom two on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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:	{0 820}	This immediate correction order identified on September 4, 2024, has had the immediacy lifted as of September 9, 2024, however non-compliance remained a scope and level of G.		

Minnesota Department of Health

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{0 820}	Continued From page 2 The immediate order issued on July 10, 2024, was for windows in bedroom one and two failing to meet minimum egress size requirements. On September 4, 2024, at 9:49 a.m., during the facility tour with CNS-A, the surveyor observed bedroom one and three. Both bedrooms had newly installed windows since the previous survey on July 9, 2024, through July 11, 2024. Both bedroom windows were measured with CNS-A's assistance and met the minimum requirements for opening height, width and openable area for egress windows. On September 4, 2024, at 9:54 a.m., during the facility tour with CNS-A, the surveyor observed bedroom two, occupied by R5, on the main floor. Bedroom two had one window which was measured with CNS-A's assistance. The clear openable area of the opened window measured 19 inches in height and 30.75 inches in width, with a total openable area of 584.25 inches. The window did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-D that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-D verbally confirmed the findings. On September 4, 2024, at 12:13 p.m., the	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 3 surveyor notified CNS-A of the reissuance of the immediate order. CNS-A stated they already informed licensed assisted living director (LALD)-D they were probably going to have a reissued egress window citation. The surveyor inquired why bedroom three's room window was replaced and not room two's. CNS-A stated there must have been some miscommunication with the contractor or something. CNS-A stated the measurements they assisted the surveyor with did not meet the minimum requirements for egress windows. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	{0 820}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 8, 2024

Licensee

Risen Home Care LLC

5333 James Avenue

Brooklyn Center, MN 55430

RE: Project Number(s) SL36999015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services \$3,000.00

St - 0 - 2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$12,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

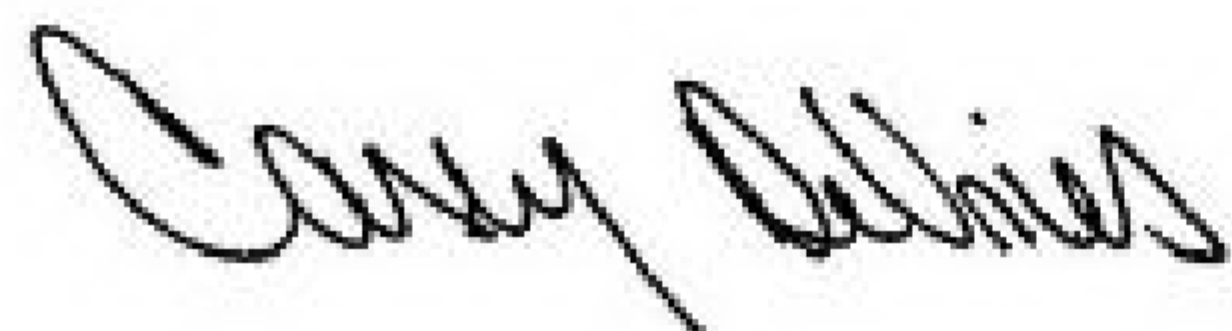
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36999	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER RISEN HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5333 JAMES AVENUE BROOKLYN CENTER, MN 55430			
(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: SL36999015-0 On July 9, 2024, through July 11, 2024, the Minnesota Department of Health conducted an Assisted Living license survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all three receiving services under the Assisted Living license. An immediate correction order was identified on July 9, 2024, issued for SL36999015-0, tag identification 0470. Immediate correction orders were identified on July 10, 2024, issued for SL36999015-0, tag 0820, 1290, 2310 and 2320. On July 11, 2024, the immediacy for correction order 0470 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 At the time of survey exit on July 11, 2024, immediacy remained for immediate correction orders 0820, 1290, 2310 and 2320. On July 16, 2024, after the survey exit, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	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 employee 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 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 employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents;	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36999	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 250	Continued From page 2 (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. (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 interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.	0 250			

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0 250	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 9, 2024, at 9:45 a.m., licensed assisted living director (LALD)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.	0 250			

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0 250	Continued From page 4 - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted	0 250			

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0 250	Continued From page 5 are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page three was electronically signed by LALD-D on November 14, 2023. The licensee had an assisted living license issued on January 1, 2024, with an expiration date of December 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees;	0 250			

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0 250	Continued From page 6 - infection control practices; - conducting initial evaluations of residents' needs and the providers' ability to provide those services; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - orientation to and implementation of the assisted living bill of rights; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On July 11, 2024, at 12:30 p.m., LALD-D confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0470, 0480, 0510, 0550, 0640, 0660, 0680, 0730, 0820, 1290, 1640, 1650, 1760, 2310, 2320 and 2410 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=H	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470			

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0 470	Continued From page 7 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 observation, interview, and record review, the licensee failed to ensure they had 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 to meet the needs of two of two residents (R2, R3), who required two-person transfers with a mechanical lift, toileting cares and bed repositioning. Further, the licensee failed to develop a staffing plan. This practice resulted in a level three violation (a	0 470			

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0 470	Continued From page 8 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). This resulted in an immediate correction order on July 9, 2024. The findings include: The licensee lacked a staffing plan. The licensee's Risen Home Care staff schedule from June 30, 2024 to August 10, 2024, indicated a variety of shift lengths and coverage which differed on a day-to-day basis with some shifts overlapping. The schedule indicated the follow staffing possibilities with each shift having one staff member scheduled per shift: -7:00 a.m. to 3:30 p.m. day shift, 2:30 p.m. to 10:00 p.m. evening shift, and 9:00 p.m. to 9:00 a.m. overnight shift; -7:00 a.m. to 3:30 p.m. day shift, 8:00 a.m. to 4:00 p.m. day shift, 2:30 p.m. to 11:15 p.m. evening shift, and 11:00 p.m. to 7 a.m. overnight shift; -7:00 a.m. to 3:30 p.m. day shift, 8:00 a.m. to 12:00 p.m. day shift, 2:30 p.m. to 10:00 p.m. evening shift, and 9:00 p.m. to 9:00 a.m. overnight shift; -7:00 a.m. to 3:30 p.m. day shift, 1:00 p.m. to 10:00 p.m. evening shift, 2:30 p.m. to 11:00 p.m. evening shift, and 11:00 p.m. to 9:00 a.m. overnight shift; and -7:00 a.m. to 3:30 p.m. day shift, 8:00 a.m. to	0 470			

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0 470	Continued From page 9 12:00 p.m. day shift, 1:00 p.m. to 10:00 p.m. evening shift, 2:30 p.m. to 11:00 p.m. evening shift, and 11:00 p.m. to 7:00 a.m. overnight shift. R2 R2 was admitted to the licensee on December 5, 2021. R2's diagnoses included morbid obesity, diabetes type two, depression, anxiety, full incontinence of feces, spina bifida, wheelchair bound and seizure disorder. R2's Service Plan dated February 23, 2022, unsigned, indicated R2 received services for transfer assistance, bathing assistance, dressing, grooming, incontinence care, repositioning/positioning and medication administration. R2's 90-Day Assessment dated May 14, 2024, indicated R2 was a two-person assist for dressing, two-person assist with bed repositioning every two hours to prevent pressure ulcers and skin breakdown, two-person assisted transfers using a Hoyer Lift, total cares with assist of two for peri-care (cleaning of private areas) and two-person assist for brief checks and changes for bowel incontinence as R2, "does not have any sensation on her lower body. [R2] will not be aware of a bowel movement." The assessment further indicated R2 had a history of skin breakdown and required special skin care and preventative skin care measures. R3 R3 was admitted to the licensee on January 1, 2024. R3's diagnoses included di-plegic cerebral palsy,	0 470			

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0 470	Continued From page 10 depression, anxiety, incontinence and delusional disorder. R3's Service Plan dated January 1, 2024, indicated R3 received services for transfer assist, incontinence care, dressing and activity assistance. R3's 90-Day Assessment dated July 9, 2024, indicated R3 was a two-person assist for dressing, two-person assist with hygiene/grooming/oral, two-person assisted transfers using a Hoyer Lift and two-person assist with toileting every two hours due to incontinence. On July 9, 2024, at 9:45 a.m., during the entrance conference, licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated they had a staffing plan. They stated their staff schedule varied from day to day with some shifts overlapping with others. They stated one unlicensed personnel was scheduled per shift. CNS-A stated they had shift overlaps to completed Hoyer lift transfers from 7:00 a.m. to 9:00 a.m., 2:45 p.m. to 3:30 p.m., and 9:00 p.m. to 11:00 p.m. CNS-A and LALD-D stated otherwise there was only one staff member here with the residents. They stated a float staff was available at two of their sister facility licensees who could be called to assist with two-person assists as needed. CNS-A and LALD-D stated one of the other licensees was two minutes away, and the other was 10 minutes away from the licensee. Additionally, CNS-A and LALD-D stated they, along with the administrator (A)-C, were available to come to the facility to help with two-person assists; CNS-A lived 18 minutes away, LALD-D 25 minutes away and A-C 15 minutes away from the licensee. The surveyor inquired how they would evacuate the building if	0 470			

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0 470	Continued From page 11 there were a fire and needed to get the residents out of the facility quickly when only one staff member was present. CNS-A stated they would call 911 for assistance. CNS-A stated staff were also trained to pull people out of the facility on their hospital beds. The surveyor inquired how that could be done on the exit ramp, a switchback style ramp, as it did not allow room for a hospital bed to maneuver around the turns. CNS-A did not give an answer. LALD-D stated one person was scheduled with some shifts overlapping but insisted someone was always close by who could come to the facility to assist residents when needed. On July 9, 2024, at 10:46 a.m., R2 stated there had been times when they wanted to get out of bed but couldn't because two people were unavailable. R2 stated there had been times where they had to wait at least 30 minutes or more. R2 stated sometimes CNS-A will be the only one available to assist and may not be available right away since CNS-A works at two other facilities. R2 stated staff had transferred them with one person in the past but it is safer for them to have two people. On July 9, 2024, at 12:18 p.m., CNS-A and LALD-D acknowledged R2 and R3 had two-person assist needs for toileting, transfers, bed mobility, brief changes and peri cares. CNS-A and LALD-D stated they did not know how frequently they should be reviewing their staffing plan. CNS-A and LALD-D both agreed the staffing policy provided was not a staffing plan and would complete one as soon as possible. On July 9 2024, at 2:28 p.m., observed CNS-A and unlicensed personnel (ULP)-E perform a two-person Hoyer lift transfer and a two-person	0 470			

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0 470	Continued From page 12 brief change for bowel incontinence for R2. Minnesota Administrative Rule 4659.0180, Subpart 5 dated August 11, 2021, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." The licensee provided an Equipment Safety policy dated August 1, 2021, which did not address two-person transfers. The licensee provided a How to Use a Hoyer Lift document. It indicated the document was adapted from www.phc-online.com/howtouseahoyer-lifta/146.htm, dated October 2013. It did not specify the number of people they required to operate a Hoyer lift. The diagrams in the document showed two people conducting the Hoyer lift transfer. The licensee's Staffing policy, undated, indicated: "A clinical nurse supervisor must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the clinical nurse supervisor must ensure that staffing levels are adequate to address the following: A. each resident's needs, as identified in the resident's service plan and assisted living contract; B. each resident's acuity level, as determined by the most recent assessment or individualized review; C. the ability of staff to timely meet the	0 470			

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0 470	Continued From page 13 residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; D. whether the facility has a secured dementia care unit; and E. staff experience, training, and competency. Direct-care staff availability. A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. Direct-care staff availability; night supervision. During the hours of 10:00 p.m. to 6:00 a.m., direct-care staff shall respond to a resident's request for assistance with health or safety needs within a reasonable amount of time as provided in Minnesota Statutes, section 144G.41, subdivision 1, clause (12), item (ii)." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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	0 480			

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0 480	Continued From page 14 prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. 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 included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 9, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on July 10, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of	0 510			

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0 510	Continued From page 15 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 9, 2024, at 2:28 p.m., the surveyor observed clinical nurse supervisor (CNS)-A and unlicensed personnel (ULP)-E perform hand hygiene, apply clean gloves, and transfer R2 into their hospital bed with a Hoyer lift (specialized mechanical lift). A bottle of hand sanitizer was available on R2's over-the-bed table next to CNS-A. CNS-A removed R2's soiled brief and began providing peri cares (cleaning private areas) with wet wipes. ULP-E assisted in rolling R2 on their side and holding R2 in place while CNS-A continued to provide peri cares. R2 continued to have a bowel movement during the brief change. CNS-A manually assisted with bowel evacuation by pushing around R2's anus. The surveyor observed CNS-A's gloves come in	0 510			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36999	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER RISEN HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5333 JAMES AVENUE BROOKLYN CENTER, MN 55430			
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0 510	Continued From page 16 contact with feces multiple times. CNS-A completed peri cares with wet wipes for R2. CNS-A did not remove their soiled gloves. The surveyor observed a stage three pressure ulcer on R2's right buttock. With soiled gloves, CNS-A handled a tube of nystatin ointment and applied it to R2's pressure ulcer. With soiled gloves, CNS-A handled a tube of barrier cream and applied it to R2's buttocks and peri area. With soiled gloves, CNS-A assisted ULP-E with positioning a new brief under R2. With soiled gloves, CNS-A touched R2's stomach, shirt, and new brief. CNS-A gathered up R2's soiled brief and wet wipes and put them in a disposable plastic grocery bag. With soiled gloves, CNS-A used the back side of one of their soiled gloves to press an automatic door opener button, for R2's bedroom door and stepped out into the living room. CNS-A removed one of the soiled gloves but did not perform hand hygiene. With their ungloved soiled hand, CNS-A opened the front door handling the doorknob and went outside of the facility to dispose of the plastic grocery bag in the outdoor garbage can. With their ungloved soiled hand, CNS-A returned inside the facility again handling the doorknob to open the front door. CNS-A removed their other soiled glove once they were back inside and then sanitized their hands using the hand sanitizer on the medication cart in the living room. On July 10, 2024, at 7:45 a.m., the surveyor observed ULP-E and ULP-F perform hand hygiene and apply clean gloves to provide a brief change for R2. A bottle of hand sanitizer was available on R2's over-the-bed table next to ULP-F. ULP-F removed R2's soiled brief and began providing peri cares with wet wipes. ULP-E assisted in rolling R2 onto their side and holding R2 in place while ULP-F continued with peri	0 510			

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0 510	Continued From page 17 cares. R2 had a small BM and ULP-F wiped R2 clean. ULP-F removed their soiled gloves and applied new gloves but did not perform hand hygiene in between, which soiled the new gloves. With soiled gloves, ULP-F handled a tube of barrier cream and applied it to R2's pressure ulcer and peri area. With soiled gloves, ULP-F assisted ULP-E to slide a new absorbent disposable bed pad and a new brief under R2. With soiled gloves ULP-F assisted ULP-E to finish applying the new brief causing ULP-E's gloves to become soiled. With soiled gloves, ULP-E pressed R2's automatic door opener button. With soiled gloves, ULP-F gathered up R2's soiled brief and wet wipes and wrapped them in the soiled bed pad and left R2's room exiting to the living room and carried the soiled items, unbagged, through the living room to the front door. With soiled gloves, ULP-F opened the front door, handling the doorknob, and went outside of the facility to dispose of the soiled items in the outdoor garbage can. With soiled gloves, ULP-F returned back inside the facility handling the doorknob to open the front door. ULP-F then removed their soiled gloves and performed hand hygiene with soap and water. On July 9, 2024, at 9:45 a.m., during the entrance conference, CNS-A stated they were the trainer for new ULP's which included infection control training and performing 30-day supervisions for ULPs. CNS-A stated they also used Educare (online training platform) for staff training. On July 9, 2024, at 2:45 p.m., CNS-A stated they did not remove their gloves or perform hand hygiene during the brief change. CNS-A stated they did remove one of their gloves before touching the automatic door opener and front doorknob stated they used a clean hand. The	0 510			

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0 510	Continued From page 18 surveyor explained if hand hygiene wasn't performed after glove removal, then their hand was still considered soiled. CNS-A stated they should have removed their gloves in between clean and dirty tasks and performed hand hygiene in between and after glove changes or removal. On July 10, 2024, at 8:00 a.m., ULP-F stated they did not perform hand hygiene between glove changes and should have removed their gloves and performed hand hygiene before leaving the room. ULP-F stated they should have used the hand sanitizer which was right next to them on the over-the-bed table. ULP-F stated they were trained to change gloves when moving from a dirty to clean task and to perform hand hygiene after glove removal. On July 11, 2024, at 12:30 p.m., CNS-A stated they would need to reeducate staff, including themselves, on proper hand hygiene and glove removal. The Center for Disease Control (CDC) Hand Hygiene Guidance last reviewed on April 12, 2024, indicated, "1. Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2. Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's	0 510			

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0 510	Continued From page 19 immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal 3. Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled. 4. Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered." The licensee's Standard Precautions for All Health Care Workers policy, undated, indicated, "Gloves should be changed after each client contact. When gloves are removed, thorough hand washing is required. Gloves do not take the place of hand washing. If glove is torn or needle stick or other injury occurs, the gloves should be removed, hands washed well, and a new glove used as promptly as client safety permits." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
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	0 550			

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0 550	Continued From page 20 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 conspicuously post the licensee's grievance procedure with name, telephone number and email contact information for individuals responsible for handling resident grievances. Additionally, the licensee failed to post contact information for the Office of Ombudsman for Long Term Care and Mental Health and Developmental Disabilities. It also lacked a notice that an individual could contact the Office of Health Facility Complaints (OHFC) if they had complaints about the facility or person providing services. 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: On July 9, 2024, at 10:24 a.m., during the facility tour with licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A, the surveyor observed the licensee lacked a grievance procedure posting, ombudsman	0 550			

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0 550	Continued From page 21 contact information and notification a complaint could be made with OHFC. Both LALD-D and CNS-A stated they were not aware the postings were required. LALD-D stated the information was provided to residents in their admission paperwork. The licensee's Grievance Policy, revised on April 19, 2019, indicated, "It is the policy of this DHS licensed provider (center) to have a program grievance procedure that permits persons served by the program and their authorized representatives to bring a grievance to the highest level of authority in the program." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	0 640			

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0 640	Continued From page 22 Based on observation and interview, the licensee failed to post the 911 emergency phone number near facility house phones. This had the potential to affect all residents, staff, and visitors at the facility. 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: The facility was a rambler style home with a main floor and a basement level. On July 9, 2024, at 10:24 a.m., during the facility tour, the surveyor observed a wireless landline house phone in the upstairs living room corner on a small table. A second wireless landline house phone was on a table in the basement. Both phones lacked a 911 posting near them. On July 9, 2024, at 11:19 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A both stated the house phones were for use by anyone including staff, residents, and visitors. CNS-A stated they were aware of the 911 posting requirement by house phones. LALD-D stated they were not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			

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0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure tuberculosis (TB) testing was completed within 90 days prior to the date of hire for one of two employees (unlicensed personnel (ULP)-E). 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: The licensee's TB risk assessment was	0 660			

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0 660	Continued From page 24 completed on January 2, 2024. The licensee was at a low risk level. ULP-E was hired on October 31, 2023, to provide direct care services to residents. ULP-E's employee record included a Result Trends form which included two TB QuantiFERON results with the most recent result on June 16, 2023, which was 137 days prior to their date of hire. On June 10, 2024, at 2:00 p.m., ULP-E stated they thought they had a TB blood test when they were hired by the licensee. On June 11, 2024, at 12:30 p.m., licensed assisted living director (LALD)-D stated ULP-E's TB testing was completed prior to 90 days of their date of hire, and they would require a new test. LALD-D stated they were aware of the TB testing requirements. The Minnesota Department of Health TB FAQ, last updated on April 3, 2024, indicated TB testing should be dated within 90 days before hiring. The licensee's Tuberculosis Screening policy, undated, indicated, "Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test. If the employee has proof of a TB blood test or negative Chest X-ray within 90 days of employment, it does not have to be repeated at the time of hire." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

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0 660	Continued From page 25 (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually 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 a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors to view.	0 680			

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0 680	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 11, 2024, the licensee's Emergency Preparedness Plan dated June 4, 2024, was reviewed by the surveyor and lacked the following required information: -Documentation of the licensee's risk assessment; -Evidence of an all-hazards approach, including EIDs, as applicable; -Evidence the licensee categorized the various probable risks/hazards by likelihood of occurrence; -Evidence the licensee developed strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); -Evidence of quarterly update for their missing resident plan quarterly; -Evidence a qualified person was designated, who is authorized in writing, to act in the absence of the administrator; -Evidence of a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; -Evidence the licensee developed and implemented EP policies/procedures (P/P) based on the EP, risk assessment & communication plan;	0 680			

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0 680	Continued From page 27 -Evidence the licensee developed and implemented EP P/P to address the following whether evacuated or shelter in place for staff/residents: -Food, water, medical supplies, pharmaceutical supplies -Identify alternate sources of energy to maintain: -Temperatures to protect resident health/safety -Safe/sanitary storage of provisions -Emergency lighting -Fire detection, extinguishing, alarm systems -Sewage and waste disposal -Evidence the licensee developed P/P for system to track the location of on-duty staff and sheltered residents; -Evidence the licensee developed P/P for if on-duty staff and sheltered residents are relocated, how the licensee must document the specific name/location of the receiving facility or other location; -Evidence the licensee developed P/P to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; -Evidence the licensee developed P/P for shelter in place for residents, staff, and volunteers who remain in the facility; -Evidence the licensee developed P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -Evidence the licensee developed P/P to address: use of volunteers, including the process/role for integration; -Evidence the licensee developed P/P to address the role of the licensee under a waiver declared	0 680			

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0 680	Continued From page 28 by the Secretary in accordance with section 1135 of the Act; -Evidence the licensee developed a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and -Evidence a communication plan was developed which included: -Method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs 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 the facility's care as permitted under 45 CFR 164.510(b)(4) On July 9, 2024, at 11:26 a.m., licensed assisted living director (LALD)-D stated the EPP binder was kept in the locked medication cart. LALD-D stated they did not have a posting which would direct a person where they could find the EPP. LALD-D stated they were aware the EPP was required to be prominently displayed and would keep it on the medication cart going forward. On July 11, 2024, at 12:30 p.m., LALD-D stated they would need to review the EPP requirements and update the missing information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36999	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER RISEN HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5333 JAMES AVENUE BROOKLYN CENTER, MN 55430			
(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
0 730	Continued From page 29	0 730			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730			

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0 730	Continued From page 30 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included documentation of all services provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 R2 was admitted to the licensee on December 5, 2021. R2's Service Plan dated February 23, 2022, indicated R2 received services for activity assistance, bathing, dressing, deep room clean, grooming, incontinence care, laundry, manage behavior, meal reminders, medication administration, positioning/repositioning, and safety checks.	0 730			

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0 730	Continued From page 31 R2's 90-Day Assessment dated May 14, 2024, indicated R2 required brief changes and positioning/repositioning every two hours. R2's Service Recap Summary for July 2024 lacked documentation for the following: -Laundry p.m., on July 2, 3, 7 and 8, 2024; -Position/Reposition 4:00 p.m., on July 2, 2024; -Safety check 4:00 p.m., July 2 and 7, 2024; -Prepare and Serve Meal 5:00 p.m., July 2, 7 and 8, 2024; -Fluid Intake 5:00 p.m., July 2, 3, 7 and 8, 2024; -Position/Reposition 6:00 p.m., July 2 and 8, 2024; -Fluid Output 6:00 p.m., July 2, 3, 7 and 8, 2024; -Safety Check 6:00 p.m., July 2, 7 and 8, 2024; -Urostomy Drainage Bag Care 6:00 p.m., July 2 and 8, 2024; -Position/Reposition 8:00 p.m., July 2 and 8, 2024; -Safety Check 8:00 p.m., July 2 and 8, 2024; -Manage Behavior - Verbal Aggression 9:00 p.m., July 2, 3, 4, 7 and 8, 2024; -Pain 9:00 p.m., July 2, 3, 7 and 8, 2024; -Manage Behavior - Agitation 10:00 p.m., July 2, 3, 4, 7 and 8, 2024; -Manage Behavior - Anxiety 10:00 p.m., July 2, 3, 4, 7 and 8, 2024; -Manage Behavior - Repetitive Behavior 10:00 p.m., July 2, 3, 4, 7 and 8, 2024; -Position/Reposition 10:00 p.m., July 2, 7 and 8, 2024; and -Safety Check 10:00 p.m., July 2, 4, 7 and 8, 2024. R2's Service Recap Summary for July 2024 indicated brief checks were not being tracked, and it indicated no positioning/repositioning was being tracked between the hours of 10:00 p.m. to 8:00 a.m.	0 730			

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0 730	Continued From page 32 R3 R3 was admitted to the licensee on January 1, 2024. R3's Service Plan dated January 1, 2024, indicated R2 received services for bathing, dressing, deep room clean, housekeeping, incontinence care, laundry, manage behavior, prepare and serve meals, medication administration, pain, safety checks, and transfer assistance. R3's Service Recap Summary for July 2024 lacked documentation for the following: -Incontinence Care 2:00 p.m., July 6, 2024; -Bowel Movement 3:00 p.m., July 3, 7 and 8, 2024; -Pain 3:00 p.m., July 3, 7 and 8, 2024; -Housekeeping, July 3 and 8, 2024; -Laundry, July 2, 2024; -Activity Assistance 4:00 p.m., July 2 and 7, 2024; -Incontinence Care 4:00 p.m., July 2 and 7, 2024; -Safety Check 4:00 p.m., July 2 and 7, 2024; -Prepare and Serve Meal 5:00 p.m., July 2, 7 and 8, 2024; -Fluid Intake 5:00 p.m., July 2, 7 and 8, 2024; -Meal Percentage 5:00 p.m., July 2, 7 and 8, 2024; -Incontinence Care 6:00 p.m., July 2 and 8, 2024; -Safety Check 6:00 p.m., July 2, 7 and 8, 2024; -Deep Room Clean 7:00 p.m., July 8, 2024; -Safety Check 8:00 p.m., July 2, 7 and 8, 2024; -Dressing 9:00 p.m., July 2, 3, 7 and 8, 2024; -Grooming 9:00 p.m., July 2, 3, 7 and 8, 2024; -Incontinence Care 9:00 p.m., July 2, 7 and 8, 2024; -Bowel Movement 9:00 p.m., July 2, 7 and 8, 2024; -Pain 9:00 p.m., July 2, 3, 7 and 8, 2024;	0 730			

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0 730	Continued From page 33 -Transfer Assistance 9:00 p.m., July 2, 7 and 8, 2024; -Incontinence Care 10:00 p.m., July 2, 7 and 8, 2024; -Manage Behavior - Anxiety 10:00 p.m., July 2, 3, 4, 7 and 8, 2024; -Manage Behavior - Repetitive Behavior 10:00 p.m., July 2, 3, 4, 7 and 8, 2024; -Safety Check 10:00 p.m., July 2, 3, 4, 7 and 8, 2024; On July 9 and 10, 2024, the surveyor observed R2 receiving medication administration, transfers, and brief changes. On July 11, 2024, at 10:58 a.m., clinical nurse supervisor (CNS)-A stated R2 and R3's missing service documentation should have been documented by staff. CNS-A stated if the resident declined the service, then it should have been documented. CNS-A stated they conducted service log audits regularly and addresses missed documentation with the individual staff. CNS-A stated they would need to reeducate staff on proper documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 820 SS=H	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	0 820			

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0 820	Continued From page 34 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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom #1 and #2 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 10, 2024, at 1:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-D. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom	0 820	This immediate correction order identified on July 10, 2024, has had the immediacy lifted as of July 16, 2024, however non-compliance remained a scope and level of H.		

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0 820	Continued From page 35 #1 and #2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 35 inches in width, with a total openable area of 560 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-D that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-D verbally confirmed the findings. On July 10, 2024, at 1:30 p.m., during the interview, survey staff explained to LALD-D that an immediate correction order was issued for the above finding. LALD-D acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290			

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01290	Continued From page 36 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living licensee's health facility identification number (HFID) 36999 for 4 of 12 employees (unlicensed personnel (ULP)-F, ULP-G, ULP-H, ULP-I). This has the potential to affect all residents residing within the facility. This resulted in an immediate correction order on July 10, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01290			

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01290	Continued From page 37 ULP-F ULP-F was hired by the licensee on September 14, 2022, and provided direct care services to residents. ULP-F worked independently with residents. On July 10, 2024, at 7:45 a.m., ULP-F was observed changing R2's incontinent product. ULP-G ULP-G was hired by the licensee on September 4, 2021, and provided direct care services to residents. ULP-G worked independently with residents. ULP-H ULP-H was hired by the licensee, (hire date unlisted) and provided direct care services to residents. ULP-H worked independently with residents. ULP-I ULP-I was hired by the licensee on December 19, 2023, and provided direct care services to residents. ULP-I worked independently with residents. On July 10, 2024, the surveyor reviewed the licensee's NETStudy 2.0 roster for HFID 36999 and compared it with the licensee's current Employee List. The NETStudy 2.0 roster indicated a BGS was not completed under the licensee's HFID for ULP-F, ULP-G, ULP-H and ULP-I. On July 10, 2024, at 2:45 p.m. licensed assisted living director (LALD)-D stated the above listed	01290			

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01290	Continued From page 38 ULP were currently employed by the licensee. LALD-D acknowledged the BGS were not on the NETStudy 2.0 roster for HFID 36999. LALD-D stated they were sure they had completed the BGS for all of them and wanted to go to their office and search their employee records. On July 10, 2024, at 3:35 p.m. LALD-D returned to the facility and had Background Study Clearance letters for ULP-G and ULP-H. ULP-G's BGS was completed under one of their sister facility's HFID 37667. ULP-H's BGS was completed under another one of their sister facility's HFID 34693. On July 10, 2024, at 4:03 p.m., LALD-D stated they searched all of their licensed facilities' HFIDs on NETStudy 2.0 and could not find completed BGSs for ULP-F or ULP-I. LALD-D stated they could not be completed due to consent and disclosure forms not being completed by ULP-F and ULP-I. The licensee's Background Studies policy, undated, indicated, "Facility requires background screening to be completed on all final candidates for employment. Unwillingness to consent to the background study will result in withdrawal of the offer of employment. Results of the background studies are confidential and are retained in confidential employee files. Employees will not be able to start working with clients until the background check clearance has been received by the Facility." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			

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01640	Continued From page 39	01640			
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 by: Based on observation, interview, and record review, the licensee failed to have a current signed service plan which identified specific services to be provided for one of two residents (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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01640			

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01640	Continued From page 40 of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on December 5, 2021. R2's Service Plan dated February 23, 2022, unsigned, indicated R2 received services for activity assistance, bathing, dressing, deep room clean, grooming, incontinence care, laundry, manage behavior, meal reminders, medication administration, positioning/repositioning, and safety checks. R2's Service Recap Summary for July 2024, indicated R2 received services for the following which were not included on the February 23, 2022, unsigned service plan: -continuous positive airway pressure (CPAP) daily management; -mechanical hoyer lift (two people transfer assistance); and -urostomy drainage bag care. R2's record lacked a current signed service plan. On July 9 and 10, 2024, the surveyor observed R2 receiving medication administration, transfers, and brief changes. On July 9, 2024, at 11:35 a.m., licensed assisted living director (LALD)-D stated R2's current service plan was not signed by R2 or licensee staff. LALD-D stated they were not sure why it was not signed but should have been by both R2 and the licensee. The licensee's Service Plan policy, undated,	01640			

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01640	Continued From page 41 indicated, "The service plan and any revisions must include a signature or other authentication by the home care provider, and by the client or client representative documenting agreement on the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
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	01650			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36999	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER RISEN HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5333 JAMES AVENUE BROOKLYN CENTER, MN 55430			
(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
01650	Continued From page 42 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 observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of two residents (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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On July 9, 2024, at 9:45 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated both LALD-D and clinical nurse supervisor (CNS)-A develop resident service plans together. R2 was admitted to the licensee on December 5, 2021. R2's Service Plan dated February 23, 2022, unsigned, indicated R2 received services for activity assistance, bathing, dressing, deep room clean, grooming, incontinence care, laundry, manage behavior, meal reminders, medication administration, positioning/repositioning, safety checks, and transfer assists. The service plan did not indicate the number of staff required to complete services.	01650			

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01650	Continued From page 43 R2's 90-Day Assessment dated May 14, 2024, indicated R2 was a two-person assist for dressing, two-person assist with bed repositioning every two hours to prevent pressure ulcers and skin breakdown, two-person assisted transfers using a Hoyer lift (specialized mechanical lift), total cares with assist of two for peri-care (cleaning of private areas), and two-person assist for brief checks and changes for bowel incontinence every two hours. On July 9, 2024, at 9:45 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated both LALD-D and clinical nurse supervisor (CNS)-A develop resident service plans together. On July 9, 2024, at 2:28 p.m., the surveyor observed R2 receiving a two-person assisted Hoyer lift transfer and a two-person assisted brief change. On July 10, 2024, at 7:45 a.m., the surveyor observed R2 receiving a two-person assisted brief change. On July 9, 2024, at 12:06 p.m., LALD-D and CNS-A stated R2's service plan did not address the number of people required to complete the service. They stated it was addressed in R2's assessments. The licensee's Service Plan policy, undated, indicated: "4. The service plan will include: a. A description of the home care services to be provided b. The staff or categories of staff that will provide the services."	01650			

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01650	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document medication administration for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01760			

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01760	Continued From page 45 The findings include: R2 R2 was admitted to the licensee on December 5, 2021. R2's Service Plan dated February 23, 2022, indicated R2 received services for medication administration. R2's Physician's Order form signed on March 11, 2024, indicated R2 took the following medications: -atorvastatin 10 milligram (mg) tablet, take one tablet by mouth (PO) at bedtime; -buspirone 10mg tablet, take two tablets PO three times daily; -Desitin max strength 40% zinc oxide, apply topically to affected areas after diaper (brief) change; -gabapentin 600mg tablet, take one tablet PO three times daily; -levetiracetam 750mg tablet, take one tablet PO twice daily; -trazodone 100mg tablet, take one tablet PO at bedtime; -calcium+D3 600mg/10 micrograms (mcg), take one tablet PO twice daily; and -cranberry 250mg capsule, take two capsules PO twice daily. R2's Medication Admin Summary (medication administration record (MAR)) for July 2024, lacked medication administration documentation for the following medications: -atorvastatin 10mg tablet, take one tablet PO at bedtime; missed documentation on July 2, 7 and 8, 2024; -buspirone 10mg tablet, take two tablets PO three	01760			

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01760	Continued From page 46 times daily, missed documentation on July 2, 7 and 8, 2024; -Desitin max strength 40% zinc oxide, apply topically to affected areas after diaper change, missed documentation on July 2, 7 and 8, 2024; -gabapentin 600mg tablet, take one tablet PO three times daily, missed documentation on July 2, 7 and 8, 2024; -levetiracetam 750mg tablet, take one tablet PO twice daily, missed documentation on July 2, 7 and 8, 2024; -trazodone 100mg tablet, take one tablet PO at bedtime, missed documentation on July 2, 7 and 8, 2024; -calcium+D3 600mg/10 micrograms (mcg), take one tablet PO twice daily, missed documentation on July 2, 7 and 8, 2024; and -cranberry 250mg capsule, take two capsules PO twice daily, missed documentation on July 2, 7 and 8, 2024. R3 R3 was admitted to the licensee on January 1, 2024. R3's Service Plan dated January 1, 2024, indicated R3 received services for medication administration. R3's Provider Contact form signed on January 11, 2024, indicated R3 took the following medications: -baclofen 20mg tablet, take one tablet PO three times daily; and -melatonin 1mg tablet, take one tablet PO at bedtime. R3's MAR for July 2024, lacked medication administration documentation for the following medication:	01760			

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01760	Continued From page 47 -baclofen 20mg tablet, take one tablet PO three times daily, missed documentation on July 1, 2, 3, 7, 8 and 10, 2024; -melatonin 1mg tablet, take one tablet PO at bedtime, missed documentation on July 2, 7, 8 and 10, 2024; and -sleep aid 25mg tablet, take half of one tablet (12.5mg) PO at bedtime, missed documentation on July 2, 7, 8 and 10, 2024. On July 11, 2024, at 10:58 a.m., clinical nurse supervisor (CNS)-A stated R2 and R3's missing medication administration documentation should have been documented by staff. CNS-A stated if the resident declined a medication, then it should have been documented as declined. CNS-A stated they conducted MAR audits regularly and addresses missed documentation with the individual staff. CNS-A stated they would need to reeducate staff on proper documentation. The licensee's Documentation of Medication Administration policy, undated, indicated, "Each medication administered by the assisted living facility staff will be documented in the resident's record. The documentation will include the signature and title of the person who administered the medication. Documentation will include the medication name, dosage, date and time administered, and method and route of administration. Staff will document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan." No further information provided.	01760			

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01760	Continued From page 48	01760			
	TIME PERIOD FOR CORRECTION: Two (2) days				
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one residents (R2) who utilized hospital bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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). This resulted in an immediate correction order on July 20, 2024. The findings include: R2 was admitted to the licensee on December 5, 2021. R2's diagnoses included morbid obesity, diabetes	02310			

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02310	Continued From page 49 type two, depression, anxiety, full incontinence of feces, spina bifida, wheelchair bound and seizure disorder. R2's Service Plan dated February 23, 2022, unsigned, indicated R2 received services for transfer assistance, bathing assistance, dressing, grooming, incontinence care, repositioning/positioning and medication administration. R2's 90-Day Assessment dated May 14, 2024, included a section on bed rail safety. It indicated the purpose for the bed rail, "to help [R2] reposition independently." It indicated R2 had a bed rail, was total cares and a Zone 2 measurement of less than 4 3/4 inches was required but lacked measurement. It indicated R2 received a new hospital bed on November 16, 2023, to help R2 reposition independently. R2's record lacked the following required components: - Measurements of entrapment zones; - Resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - Resident preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On July 9, 2024, at 10:24 a.m., during the facility tour, the surveyor observed R2's hospital bed which had two rectangle half rails with vertical bar at the head of both sides of the bed. The hospital bed had the left side of the bed pushed up	02310			

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02310	Continued From page 50 against the east wall of the room. On July 9, 2024, at 2:28 p.m., the surveyor observed R2 use the bed rails for bed mobility while receiving a brief change from two unlicensed personnel (ULP). On July 10, 2024, at 8:45 a.m., clinical nurse supervisor (CNS)-A stated they had not performed measurements on R2's bed rails or entrapment zones since their admission. CNS-A stated R2 had the hospital bed when they were admitted. CNS-A stated they used the template for bed rail assessments in Rtasks (charting software) within the 90-day assessment. CNS-A stated they did not know how frequently bed rail assessments should be completed, they just do them with every 90-day assessment. CNS-A stated R2 used the bed rails for mobility and was able to show where it was documented in the May 14, 2024, 90-day assessment. CNS-A stated they had discussed risk vs. benefits specific to R2 with R2 but did not have documentation it had occurred. CNS-A stated when R2 received a new hospital bed on November 16, 2023, they did an inspection of the bed but did not complete measurements of entrapment zones or evaluate for new risks. CNS-A stated they did consult the manufacturer instructions when inspecting the hospital bed. The surveyor requested a copy of the manufacturer instructions but CNS-A stated they did not think they had a copy. CNS-A stated the company who provided the bed installed the bed rails on R2's bed. CNS-A stated they had not considered or try alternatives to the bed rails. CNS-A stated R2 wanted the hospital bed. CNS-A stated they were not currently familiar with all of the bed rail requirements discussed. On July 10, 2024, at 9:02 a.m., R2 stated she	02310			

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02310	Continued From page 51 was not informed of the risk vs. benefits of bed rails and did not know there were risks involved with them. R2 stated no one had measured the entrapment zones of the bed rail to their knowledge. R2 stated they wanted, and liked, the bed rails so they could remain as independent as possible and assist with bed mobility even though she required assistance from two people. The surveyor observed, wiggled and pulled on R2's bed rails which were firmly attached to the bed. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated April 3, 2024, indicated, " To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail	02310			

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02310	Continued From page 52 has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee provided a Clinical Guidance document, 18 pages long, developed by the Hospital Bed Safety Workgroup in April 2003. It indicated, "Every patient, regardless of care setting, deserves a safe and comfortable sleeping and bed environment. The goal of this clinical guidance is the provision of such an environment to patients in hospitals, long term care facilities, and home care settings. (Note: The term patient as used in this document refers to patients in hospitals, residents in long term care facilities, and clients in home care settings.) The purpose of this guidance is to provide a uniform set of recommendations for caregivers in hospitals, long term care facilities, and home care settings to use when assessing their patients' need for and possible use of bed rails. The guidance is deliberately basic in design and content to allow each setting to adapt it to meet the unique needs of their respective patients and environments."	02310			

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02310	Continued From page 53 The licensee's Use of Side Rails in the Home policy, undated, indicated, "Side rails will not be used in the home setting except in situations where assessment determines they are necessary for safety of the client. If the client or client's representative wants side rails on the bed, Facility RN will educate the client/representative about the risks related to side rails, and will assess whether the side rails meet FDA standards. If the side rails do not meet safety guidelines, staff will recommend alternative options to reduce the fall risk. Physician orders will be obtained for the side rails if indicated." Additionally, it indicated: 1. "When notified that a client has a side rail or that the client or their representative is requesting side rails, the RN will assess and evaluate what the client's needs are and if the client can safely utilize the side rail/equipment. Assessment will determine whether the equipment meets the FDA standards for side rails. 2. If the RN determines that the client is not able to safely use a side rail, or that the client's side rail does not meet the FDA or most current safety guidelines, the RN will recommend that the side rail should be removed and will document this recommendation. The RN will document the teaching provided regarding the risks of using side rails. Documentation will include family members or other caregivers who received the education and if request to remove side rail, will document the person who was given the recommendation to remove the side rail. 3. If the RN determines that the side rails are not a safe device for the client, the RN will provide options and alternatives for reducing fall or positioning self to the client, the client's representative and/or the client's family. The RN will document these recommended options and	02310			

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02310	Continued From page 54 the response from the client, client's family and client's representative to the RN's recommendations. 4. A detailed document on side rails is found at http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm072729.pdf . 5. Detailed information from FDA about Side Rail Safety, including information for both health care providers and for consumers and caregivers is found at: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/default.htm . The web page for consumers and caregivers can be printed as a handout for home care clients and their families." No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for pressure ulcer	02320			

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NAME OF PROVIDER OR SUPPLIER RISEN HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5333 JAMES AVENUE BROOKLYN CENTER, MN 55430		
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02320	Continued From page 55 prevention for one of one resident (R2). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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). This resulted in an immediate correction order on July 10, 2024. The findings include: R2 was admitted to the licensee on December 5, 2021. R2's diagnoses included morbid obesity, diabetes type two, depression, anxiety, full incontinence of feces, spina bifida, wheelchair bound and seizure disorder. R2's Service Plan dated February 23, 2022, unsigned, indicated R2 received services for transfer assistance, bathing assistance, dressing, grooming, incontinence care, repositioning/positioning and medication administration. R2's 90-Day Assessment dated May 14, 2024, indicated R2 was a two-person assist for dressing, two-person assist with bed repositioning every two hours to prevent pressure ulcers and skin breakdown, two-person assisted transfers using a Hoyer Lift, total cares with assist of two for peri-care (cleaning of private areas) and two-person assist for brief checks and changes	02320			

Minnesota Department of Health

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02320	Continued From page 56 for bowel incontinence every two hours as R2, "does not have any sensation on her lower body. [R2] will not be aware of a bowel movement." The assessment further indicated R2 had a history of skin breakdown and required special skin care and preventative skin care measures. R2's Resident Notes (weekly nursing note) for July 1, 2024, at 8:42 a.m., in Rtasks (charting software), completed by clinical nurse supervisor (CNS)-A, indicated, "Skin Issues: A rash was noticed on the left buttock and popliteal areas. Staff continued applying topical desitin cream/nystatin powder to the affected rash areas." R2's Resident Notes (weekly nursing note for July 8, 2024, 8:20 a.m., in Rtasks, completed by CNS-A, indicated, "Skin Issues: A rash was noticed on the left buttock and popliteal areas. Staff continued applying topical desitin cream/nystatin powder to the affected rash areas." R2's Service Recap Summary for July 2024, indicated bowel movements were recorded, however, brief checks were not being tracked. It indicated no positioning/repositioning was being documented between the hours of 10:00 p.m. to 8:00 a.m. It indicated the following missed services: -positioning/repositioning at 4:00 p.m. 6:00 p.m. 8:00 pm. 10:00 p.m., on July 2, 2024; -positioning/repositioning at 10:00 p.m., on July 7, 2024; and -positioning/repositioning at 6:00 p.m. 8:00 pm. 10:00 p.m., on July 8, 2024. R2's Wound Care note dated July 10, 2024, at 10:57 a.m., in Rtasks, indicated, "Open wound,	02320			

Minnesota Department of Health

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02320	Continued From page 57 1st degree, 2"x1", and moist. Desitin cream applied by staff TW." On July 9, 2024, at 2:28 p.m., the surveyor observed CNS-A and unlicensed personnel (ULP)-E perform a brief change for R2 after a bowel movement. The surveyor observed a stage three pressure ulcer (PU) on R2's right buttocks approximately two by one inches in size. CNS-A cleansed the wound and applied a Nystatin ointment to the PU. On July 10, 2024, at 7:45 a.m., the surveyor observed ULP-E and ULP-F perform a brief change for R2. The surveyor observed a stage three PU on R2's right buttocks approximately two by one inches in size. ULP-F applied barrier cream to the PU. On July 10, 2024, at 10:35 a.m., CNS-A stated the R2's PU is new from just a few weeks ago. The surveyor inquired about wound treatments, measurements, interventions and wound assessment documentation. CNS-A stated they were in their resident notes and would provide them. On July 10, 2024, at 11:19 a.m., the surveyor reviewed CNS-A's resident notes from July 1 and 8, 2024. Neither resident note indicated the presence of a pressure ulcer on R2's right buttocks. They did indicate a rash on R2's left buttocks. CNS-A stated the wound showed up yesterday (July 9, 2024) and was notified of it by staff just prior to the surveyors arrival. CNS-A stated they first observed and assessed the wound on July 9, 2024, at 2:28 p.m., while the surveyor observed R2's brief change. CNS-A stated they were currently completing documentation of the July 9, 2024, observation.	02320			

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02320	Continued From page 58 CNS-A stated they did not start the charting of the wound until today (July 10, 2024). On July 10, 2024, at 11:28 a.m., R2 stated staff were not repositioning or checking their brief every two hours like they were supposed to be. R2 stated, "how can they be doing that if they don't have two people here all of the time?" R2 stated they were not checking on them every two hours, especially at night. R2 stated they were not aware of the presence of a PU on her buttocks. R2 stated they could not feel anything below their waist which was why they required brief checks. On July 10, 2024, at 11:41 a.m., ULP-E stated they first noticed R2's PU when they returned from vacation on July 5, 2024, and notified CNS-A of its presence. On July 10, 2024, at 11:57 a.m., the surveyor interviewed CNS-A about their wound assessment completed on July 10, 2024, at 10:57 a.m. The surveyor asked what CNS-A meant by a, "first degree" wound and to give a definition. CNS-A stated a first degree wound was when the skin was broken down and open, you could start to see tissue. The surveyor inquired if CNS-A was familiar with PU staging. CNS-A stated they got confused with burns by using the term, "degree," instead of, "stage." CNS-A defined a stage one PU was when the skin was broken down, open and red, a stage two PU was when the skin had broken down and tissue was exposed with white tissue (CNS-A was describing dead tissue called slough) forming, and a stage three PU would be deeper red tissue with veins. CNS-A then stated the R2's PU was more of a stage two PU than a stage one PU which they had originally charted in the wound assessment. The surveyor showed CNS-A a PU staging chart from the Minnesota	02320			

Minnesota Department of Health

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02320	Continued From page 59 Hospital Association Patient Safety resource. CNS-A stated R2's PU should have been identified as a stage three. CNS-A stated they were working on further interventions for R2's PU and were currently treating with Nystatin ointment and barrier cream. The Minnesota Hospital Association Patient Safety resource defines staging of PU as follows: -Stage one: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from surrounding area; -Stage two: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister; -Stage three: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling; - Stage four: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling; and - Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02320			

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02410	Continued From page 60	02410			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support reasonable privacy when staff did not close a resident's door while providing cares and services for one of one resident (R2). Additionally, R2's bedroom door did not have a locking mechanism to provide reasonable privacy. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02410			

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02410	Continued From page 61 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on December 5, 2021. R2's Service Plan dated February 23, 2022, indicated R2 received services for activity assistance, bathing, dressing, deep room clean, grooming, incontinence care, laundry, manage behavior, meal reminders, medication administration, positioning/repositioning, and safety checks. On July 9, 2024, at 10:24 a.m., during the facility tour with licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A, the surveyor observed R2's room on the main floor which had a remotely operated barn-style sliding door controlled by three remote controls. R2's room door separated their room from the living room. One remote control was just outside of R2's room door, another just inside R2's room door and a third on a dresser in R2's room. When the remote button was pressed the door opened up completely. LALD-D and R2 both stated the door lacked a locking mechanism. On July 9, 2024, at 10:46 a.m., R2 stated their door did not lock and it bothered them. R2 stated sometimes staff entered their room without knocking. R2 stated when the remote control button was pressed it opened the door completely. R2 stated staff would go in and out of	02410			

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02410	Continued From page 62 their room during cares which required them to open the door. R2 stated, "I feel exposed," when staff opened the door during cares. R2 stated on multiple occasions there had been residents and visitors in the living room, just outside their room door, who could look into their room while they were exposed. On July 10, 2024, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-F enter R2's room to provide cares. ULP-F left R2's door open while they check R2's blood glucose (BG), administered medication, and emptied R2's urostomy bag which required R2's shirt to be lifted up. The surveyor observed R4 sitting on the living room couch looking into R2's room while the cares and services were performed. On July 10, 2024, at 9:02 a.m., R2 stated they did not like the lack of privacy during their BG check, medication pass, and urostomy cares earlier in the morning. On July 11, 2024, at 12:30 p.m., LALD-D and CNS-A stated they were unaware R2's privacy was a concern. They stated the expectation was for a resident's door to be closed for privacy during cares and services. They stated the door R2 had on their room helped provide R2 with independence and they would try and figure out a solution to respect R2's privacy. The licensee's Client Security and Privacy policy, undated, indicated: "1. PRIVACY: a. Employees are encouraged to keep the client covered at all times and to provide a drape when directly working with the client. b. Visitors and others are asked to leave when care is being given.	02410			

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02410	Continued From page 63 c. Any photos taken are for the purpose of documentation and are taken only with the client's written consent. d. Agency will assign medical record and data entry staff to maintain client records and files confidentially. e. All information maintained in computer records will be password protected, and only authorized personnel will have access. All employees that have passwords to access the Agency and client information will keep the password protected and not allow others to know the password or use it. f. Client information will not be visible on computer monitors when not in use. g. Client records in the home will be labeled as confidential and kept in a secure location by the client. h. Information given to employees will be limited to a "need to know" basis. i. All employees will be oriented to the privacy requirements and the consequences of violating client privacy." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			

Type: Full
Date: 07/09/24
Time: 08:58:29
Report: 7963241053

Food and Beverage Establishment Inspection Report

Page 1

Location:

Risen Home Care Llc
5333 James Avenue
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:

ID #: 0039214
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 **** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

KITCHEN REFRIGERATOR- MILK AT 50 DEG F AND HOT DOGS AT 49 DEG F. SOME FOODS DISCARDED, OTHER MOVED TO ALTERNATE REFRIGERATION.

Comply By: 07/09/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD MANAGER CERTIFICATE ON SITE.

Comply By: 07/10/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

KITCHEN REFRIGERATOR RUNNING WARM. REPAIR, ADJUST OR REPLACE.

Comply By: 07/09/24

Food and Equipment Temperatures

Type: Full
Date: 07/09/24
Time: 08:58:29
Report: 7963241053
Risen Home Care Llc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: HOT DOGS
Temperature: 49 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Process/Item: MILK
Temperature: 50 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

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

MET WITH ESTABLISHMENT REPRESENTATIVE ANGELIQUE CAPILA AND MDH NURSE SURVEYOR JOEY KEEN.

DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-HAND WASHING
-SANITIZING DISHES
-THERMOMETERS
-FOOD COLD HOLDING REQUIREMENTS

THIS IS A RESIDENTIAL HOME THAT DOES SAME-DAY MEAL SERVICE.
IT HAS A RESIDENTIAL DISHWASHER WITH A SANITIZER CYCLE.

FLOORING IS LINOLEUM, SMOOTH PAINTED CEILING, LAMINATE COUNTERTOPS AND WOOD CABINETS.

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 7963241053 of 07/09/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Angelique Capila
PIC

Signed: _____



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