Electronically Delivered

March 6, 2024

Licensee
Rise Residential Services SC
8424 Clinton Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL39303015

Dear Licensee:

On January 30, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 30, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 30, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 30, 2023, found not corrected at the time of the January 30, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0460-Minimum Requirements-144g.41 Subdivision 1 - $500.00
0690-Resident Record-144g.43 Subdivision 1 - $500.00
1330-Unlicensed Personnel-144g.60 Subd. 4 (b) - $500.00
1470-Content Of Required Orientation-144g.63 Subd. 2 - $500.00

The details of the violations noted at the time of this follow-up survey completed on January 30, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on January 30, 2024, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)
0730-Contents Of Resident Record-144g.43 Subd. 3
0950-Designation Of Representative-144g.50 Subd. 3
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1770-Documentation Of Medication Setup-144g.71 Subd. 9

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. 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.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

REQUESTING A HEARING

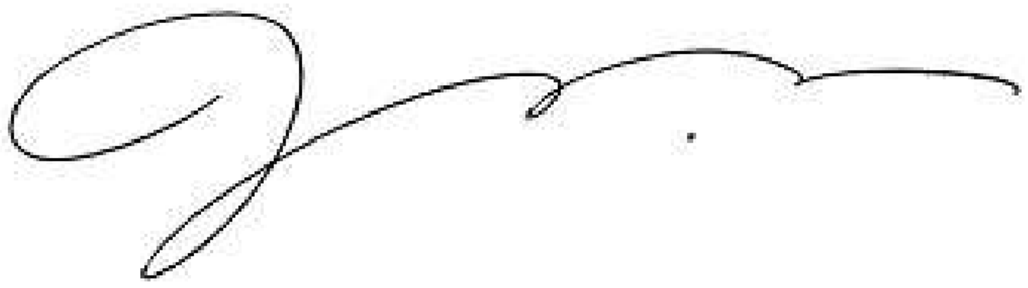
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39303	A. BUILDING: _____ B. WING _____	R 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISE RESIDENTIAL SERVICES SC	8424 CLINTON AVENUE SOUTH BLOOMINGTON, MN 55420

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL39303015-1 On January 29, 2024, through January 30, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 30, 2023. At the time of the survey, there was one (1) resident receiving services under the Assisted Living license. As a result of the revisit, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 144G.31 subd. 1, 2, and 3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a	0 340		

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0 340	Continued From page 1 complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed November 30, 2023. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 340		

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0 340	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 30, 2023, at 9:06 a.m., the licensee was provided an exit email related to the conclusion of the licensee's provisional initial survey. The email was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C and included a link hosted on the Minnesota Department of Health's website for the Correction Order Documentation Guidelines document. On December 28, 2023, at 9:24 a.m., the licensee received the results of the survey concluded on November 30, 2023. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results. This date was January 18, 2024. On January 29, 2024, at 10:00 a.m., upon the initiation of the licensee's revisit survey, LALD/CNS-C stated licensee had not documented any corrective actions taken to address orders from the initial survey. LALD/CNS-C stated licensee was meeting with a consultant in the near future and was waiting until after meeting with a consultant to address and document corrective actions taken for all orders received. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		

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{0 460}	Continued From page 3	{0 460}		
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	{0 460}		

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{0 460}	Continued From page 4 portion or all the residents). The findings include: On January 29, 2024, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they have not implemented a call system yet. LALD/CNS-C stated licensee would order a call system from an online store, but they have not submitted the order yet. The licensee's undated Call Light Policy indicated the residents will be provided summoning devices/call light to request assistance for health and safety needs 24 hours a day seven days a week. No further information was provided.	{0 460}		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an	0 630		

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0 630	Continued From page 5 individual abuse prevention plan (IAPP) with required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: R2 was admitted to facility and signed [licensee] Services SC Assisted Living Contract on January 15, 2024, with diagnoses including bipolar disorder (mood disorder) and depression. R2's Assessment As Of Date dated January 22, 2024, under section Safety, read "Vulnerability, Is not at risk to be abused" and "Resident has a history of attempted suicide or history of suicide attempt by cutting left wrist in thoughts of suicide, specify with measures to attempt to bleed. Reduce risk." R2's assessment lacked assessment of the resident's susceptibility to abuse other vulnerable adults and the risk of causing harm to other vulnerable adults; it fails to identify specific interventions for R2's identified vulnerability. On January 30, 2024, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C indicated the licensee's IAPPs are contained in each resident assessment. LALD/CNS-C indicated the licensee recently transitioned to a new electronic medical record and failed to include all the required information.	0 630		

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0 630	Continued From page 6 The licensee's 6.05 Individual Abuse Prevention Plan policy dated February 1, 2023, read, "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults, b. the person's risk of abusing other vulnerable adults, and, C. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
{0 690} SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	{0 690}		

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{0 690}	Continued From page 7 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on January 15, 2024. R2's Resident [licensee] Services CHARTING SHEET Room #2 with dates from January 15, 2024, thru January 19, 2024, was identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as documented evidence of services R2 received. The document was laid out in a grid labeled Saturday through Friday across the top and different activities of daily living (ADLs) and services listed down the left side with boxes for documentation to be placed once a service was provided on the corresponding day. In the boxes, check marks were placed to identify what day and what service was provided. The document lacked identification of which staff performed which services for R2. On January 29, 2024, at 10:30 a.m., LALD/CNS-C stated the licensee is consulting with [3rd party consulting agency] and still learning the licensee's software program. LALD/CNS-C indicated licensee had provided the services to R2. LALD/CNS-C was not able to identify which staff completed the services that were checked off indicating they were completed. The licensee's 2.37 Resident Record - Documentation policy dated February 1, 2023, read, "All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there	{0 690}		

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{0 690}	Continued From page 8 is a completed signature page included in the documentation." No further information provided.	{0 690}		
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	0 730		

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0 730	Continued From page 9 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 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 interview and record review, the licensee failed to develop and maintain resident records with all required content related to provider orders for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to facility on January 15, 2024, with diagnoses including bipolar disorder (mood disorder) and depression. R2's record lacked signed provider orders.	0 730		

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0 730	Continued From page 10 On January 29, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided R2's requested record. LALD/CNS-C stated provider orders had to be requested from the pharmacy since these were not maintained in the resident record. The licensee's 7.20 Medications & Treatment Orders policy dated January 1, 2024, indicated current and written prescribers order must be obtained for any treatment or medication administration provided to a resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		

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{0 810}	Continued From page 11	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39303	A. BUILDING: _____ B. WING _____	R 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISE RESIDENTIAL SERVICES SC	8424 CLINTON AVENUE SOUTH BLOOMINGTON, MN 55420

(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
{0 810}	Continued From page 12	{0 810}		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 950	Continued From page 13 representative statutory language notice for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on January 15, 2024. R2's [licensee] Services SC Assisted Living Contract, dated January 15, 2024, lacked the verbatim designated representative notice, a location to identify a designated representative, or a space for the resident to initial if they wished to decline to name one. On January 30, 2024, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the assisted living contract did not include the designation of representative statutory language notice and would need to be added to the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
{01330} SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:	{01330}		

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{01330}	Continued From page 14 (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one employee (unlicensed personnel (ULP)-A). 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: ULP-A was hired on February 16, 2023.	{01330}		

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{01330}	Continued From page 15 ULP-A's record lacked evidence ULP-A was trained and demonstrated competency as required. On January 29, 2024, at 10:00 a.m., upon the initiation of the licensee's revisit survey, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee had not provided the required training and competencies for staff. LALD/CNS-C stated licensee had recently started using an electronic training program but had not implemented the program within the required time period for correction and no staff had completed any additional training since licensee's initial survey. The licensee's 5.02 Competency Training Evaluations policy dated February 1, 2023, indicated all ULPs would be trained and would demonstrate competency in the statutorily required areas. No further information provided.	{01330}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	{01470}		

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{01470}	Continued From page 16 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	{01470}		

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{01470}	Continued From page 17 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-A, registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-A and RN-B were hired on February 16, 2023, and September 22, 2023, respectively. ULP-A and RN-B's records lacked evidence they were orientated to all required orientation content. On January 29, 2024, at 10:00 a.m., upon the initiation of the licensee's revisit survey, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee had not provided the required orientation for staff. LALD/CNS-C stated licensee had recently started using an electronic training program but had not implemented the program within the required time period for correction and no staff had completed any required orientation since licensee's initial	{01470}		

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{01470}	Continued From page 18 survey. The licensee's 5.02 Competency Training Evaluations policy dated February 1, 2023, indicated all ULPs would be trained and would demonstrate competency in the statutorily required areas. No further information provided.	{01470}		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01640		

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01640	Continued From page 19 licensee failed to ensure the current service plan included a signature or other authentication by the licensee and the resident or resident's designated representative to document agreement on the services to be provided for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on January 15, 2024. R2's Assessment As Of Date dated January 22, 2024, indicated R2 received services for medication management and reminders for activities of daily living (ADLs). R2's record lacked a service plan with authentication by the resident or resident's designated representative. On January 30, 2024, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee had recently started to use a new electronic health record (EHR) that will develop a service plan for all residents, but licensee had not fully implemented the new system yet. LALD/CNS-C stated an authenticated current service plan would not be in R2's record.	01640		

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01640	Continued From page 20 The licensee's Service Plan policy dated February 23, 2022, indicated a service plan would be developed, implemented, and authenticated for each resident beginning when assisted living services were provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of a medication setup was accurate for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01770		

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01770	Continued From page 21 R2 was admitted on January 15, 2024. R2's Assessment As Of Date dated January 22, 2024, read under the section Medications, "Med Management. Needs full medication management and setup. Medications are locked in the medication cabinet. [R2] sets up [R2's] medication weekly in the medication organizer. [R2] administers [R2's] medications on time and notifies staff that [R2] took [R2's] medications. Staff then documents." On January 29, 2024, at 11:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided a documented titled RN Medication Setup dated for January 15, 2024, and January 22, 2024. Each date indicated LALD/CNS-C had set up R2's medications but the document lacked the name of medication(s), quantity of dose, times to be administered, and route of administration as required for medication set up documentation. On January 29, 2024, at 11:45 a.m., LALD/CNS-C stated document is stored in a Google Doc (online document organization tool) and LALD/CNS-C was licensee's documentation when medications were set up with R2. The licensee's 7.09 Medication Management - Dosage Box Setup policy dated January 1, 2024, indicated documentation would have included the required documentation and would be documented on the medication administration record (MAR). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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Electronically Delivered

December 28, 2023

Licensee
Rise Residential Services SC
8424 Clinton Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL39303015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on November 30, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration 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/or state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL39303015-0 On November 27, 2023, through November 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were no active residents receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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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
0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee's licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C was listed as the Director of Record (DOR) for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: LALD/CNS-C was licensed on November 1, 2021. On November 28, 2023, at 10:30 a.m. during the entrance conference, LALD/CNS-C was directed to the BELTSS website on LALD/CNS-C's laptop. LALD/CNS-C stated the licensee was not aware the LALD was required to assign themselves as the DOR for the licensee. LALD/CNS-C proceeded to log into the BELTSS website and surveyor observed them assign themselves as the DOR for licensee. LALD/CNS-C stated the	0 110		

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	39303	A. BUILDING: _____ B. WING _____	11/30/2023

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0 110	Continued From page 2 licensee was not aware of requirements and restrictions BELTSS had on the number and distances of locations the LALD could be assigned. The licensee's 4.01 Assisted Living Director policy dated February 1, 2023, failed to identify the LALD would be assigned as the Director of Record for the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 250		

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0 250	Continued From page 3 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; (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 ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the	0 250		

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0 250	Continued From page 4 assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's "Provisional Application for Assisted Living License," dated June 9, 2022, signed by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C, section titled "Official Verification of Owner or Authorized Agent", (page 17 and 18 of the application), read, "I certify I have read and understand the following:" [a box filled in indicated completion of each of the following]: - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the	0 250		

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0 250	Continued From page 5 licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence f 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 (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page 18 was electronically signed by the owner (LALD/CNS)-C) on June 9, 2022. The licensee was issued an assisted living license, effective September 13, 2022. During the licensee's provisional (first) survey concluded on November 30, 2023, sixteen (16) correction orders being issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. On November 28, 2023, at 10:30 a.m. during the entrance conference, LALD/CNS-C stated they understood the current minimum assisted living requirements. On November 28, 2023, at 1:15 p.m., surveyor	0 250		

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0 250	Continued From page 6 asked if LALD/CNS-C had read Minnesota statutes 144G as LALD/CNS-C indicated they were unfamiliar with the statutorily requirements related to nursing assessment, service plan content, employee training, employee competency testing, a means for residents to summon assistance, and documentation requirements for services to be provided to residents. LALD/CNS-C stated they were not familiar with the regulations as attested on the licensee's application. Although LALD/CNS-C stated they had purchased a complete policy and procedures package from a care provider group, LALD/CNS-C stated they were not aware of all the contents and had not implemented each of the policy and procedures. The licensee's failure to implement the policy and procedures resulted in multiple citations being issued during the course of the survey and the failure of LALD/CNS-C's understanding of the day-to-day operations of the licensee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to	0 460		

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0 460	Continued From page 7 have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted on February 18, 2023, with diagnoses which included dementia with behavioral issues, chronic pain related to arthritis, anxiety, and tardive dyskinesia (an irreversible movement disorder that causes a range of repetitive muscle movements in the face, neck, arms, and legs). On November 28, 2023, at 10:30 a.m. during the entrance conference, licensed assisted living director/clinic nurse supervisor (LALD/CNS)-C stated the licensee had not purchased nor	0 460		

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0 460	Continued From page 8 implemented a means for a resident to request assistance for health and safety needs. LALD/CNS-C stated the licensee had researched a couple options via online shopping but the licensee had not purchased one. LALD/CNS-C stated R1 did not have a means to request assistance for health or safety during the time they were admitted to the licensee's care. LALD/CNS-C stated R1 would call out if they needed assistance from staff. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service;	0 485		

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0 485	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's assisted living contract required residents to pay for meals, housekeeping, and laundry services. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 18, 2023. R1's [licensee] Assisted Living Contract signed February 21, 2023, read, "Subject to the Resident's needs, [licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [licensee]. 2. Housekeeping services include vacuuming, dusting cleared surfaces, cleaning the bathroom and changing bed linens. 3. Laundry: [licensee] provides clean linens (towels, bedding and blankets) for all residents ...b. Personal laundry service includes pick-up and delivery for two loads of laundry per week." On November 28, 2023, at 10:30 a.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee was not aware the identified	0 485		

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0 485	Continued From page 10 services could not be required to be paid for in the licensee's contract. LALD/CNS-C stated the contract used for R1 was the licensee's current contract that would be used for all residents. LALD/CNS-C stated the licensee would need to edit the contract to remove the services that could not be required to be paid for and included in the assisted living contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.	0 580		

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0 580	Continued From page 11 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 November 28, 2023, at 10:30 a.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had not initiated a QMP as licensee currently did not have residents under licensee's care. LALD/CNS-C stated a resident was admitted and discharged in February 2023, but a QMP was never implemented when the licensee had a resident under their care. LALD/CNS-C stated a QMP would need to be identified and initiated. The licensee's 2.31 Quality Management Project policy dated February 1, 2023, indicated the licensee would develop, maintain, and document evidence of at least one quality management project and retain the records for two years. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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	0 660		

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0 660	Continued From page 12 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening and a negative IGRA (serum blood test) or Two-Step Mantoux TST (tuberculin skin test) dated within 90 days before hire for one of two employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 660		

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0 660	Continued From page 13 ULP-A was hired on February 16, 2023. ULP-A's CVS Health minute clinic document dated February 26, 2023, indicated ULP-A completed the first of two TST, but ULP-A's record lacked evidence ULP-A completed the required second step TST. ULP-A record also lacked a health history and symptom screening related to TB. On November 28, 2023, at 12:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-A had not completed the required second step of the TST and had not completed a health history and symptoms screening. LALD/CNS-C stated the licensee was not aware a second step was required as the licensee had never administered a second step test before. LALD/CNS-C stated the licensee had not completed a second step TST on any staff who required a second step TST. LALD/CNS-C stated the licensee was not aware why ULP-A's record lacked a healthy history and screening. The Minnesota Department of Health (MDH) Tuberculin Skin Test information website retrieved November 29, 2023, indicated Two-Step TSTs were required for HCWs (health care workers) who provided care in facilities which the licensee fell under. The licensee's 8.16 Tuberculosis Screening policy dated February 1, 2023, indicated the licensee would complete health history and symptom screening along with completed IGRA and TST results for all employees who provided care and worked within the same air space as residents. No further information provided.	0 660		

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0 660	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted on February 18, 2023. R1's Home Health Aide Charting Sheet dated February 22, 2023, was identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as documented evidence of	0 690		

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RISE RESIDENTIAL SERVICES SC	8424 CLINTON AVENUE SOUTH BLOOMINGTON, MN 55420

(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
0 690	Continued From page 15 services R1 received. The document was laid out in a grid labeled Saturday through Friday across the top and different activities of daily living (ALDs) and services listed down the left side with boxes for documentation to be placed once a service was provided on the corresponding day. In the boxes, check marks were placed to identify what day and what service was provided. On November 28, 2023, at 12:50 p.m., LALD/CNS-C stated they, along with unlicensed personnel (ULP)-A, had provided the services to R1, but LALD/CNS-C was unsure which check marks belonged to ULP-A and which were placed by LALD/CNS-C. LALD/CNS-C stated the licensee was not aware documentation in the resident's record was required to be authenticated by the person who was making the entry and completed providing the services. LALD/CNS-C stated the licensee would need to educate staff to each document their own initials when they had completed a service provided to a resident. The licensee's 2.37 Resident Record - Documentation policy dated February 1, 2023, read, "All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 690		

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0 790	Continued From page 16	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on November 28, 2023, at 11:15 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, it was observed the fire extinguisher provided had a manufacture	0 790		

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0 790	Continued From page 17 date of 2020 and records of annual service for the extinguisher were not available at the time of the tour. At least one fire extinguisher with minimum 2-A:10-B:C (size) rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on November 29, 2023, at 9:45 a.m., LALD/CNS-C, verified this deficient finding. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 18 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 19 On November 29, 2023, licensed assisted living director/ clinical nurse supervisor (LALD/ CNS)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated February 1, 2023, failed to include the following: The FSEP did not identify specific fire protection actions for residents evident by not including language for actions residents are required to take in the event of a fire or similar emergency. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include a list of specific unique or unusual needs for evacuation for each resident, to be referenced for communication by staff and emergency responders in the event of a fire or similar emergency. During an interview on November 29, 2023, at 9:45 a.m., LALD/ CNS-C stated this documentation was available but is not included with the FSEP. No further records were provided. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill	0 810		

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0 810	Continued From page 20 every other month as evident by providing records of drills completed February 17, 2023, at 8:00 a.m. and 11:00 a.m., May 5, 2023, at 10:00 p.m. and 11:00 p.m., and September 31, 2023, at 3:00 p.m. and 4:00 p.m. During an interview on November 29, 2023, at 10:00 a.m., LALD/ CNS-C stated the drills were conducted in only three months in 2023 and drills will be completed and documented in the sequence required in the future. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety) and was issued at a widespread	0 970		

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0 970	Continued From page 21 scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 18, 2023. R1's [licensee] Assisted Living Contract signed February 21, 2023, read under Miscellaneous Provisions 1. Insurance Liability and Release, "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage," and under Indemnification, "[licensee] shall not be liable for any damage or injury to the resident." On November 28, 2023, at 10:30 a.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee was not aware a liability waiver could not be included in the contract. LALD/CNS-C stated the contract signed by R1 was the licensee's current contract used for all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=C	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060		

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01060	Continued From page 22 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	01060		

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01060	Continued From page 23 Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 18, 2023. R1's RTasks Notes dated February 22, 2023, read, "EMS[Emergency medical services] arrived at 1:30 PM. Assessed pt [patient] and determined the client needs to be admitted to the hospital. [R1] was asking EMS to get valium medication. The client left with the EMS around 1:50 PM." Additionally, the note read, "Brother reported that [R1] would need a place that could provide higher care for dementia patients such as the memory care unit of presbyterian homes. Based on pt's escalating behavior the client needs a higher level of care and writer agreed. Around 5:00 PM [R1's] brother called and reported that he needs to get [R1's] belongings at the end of this week." R1's record lacked documentation the resident or designated representative was provided a written	01060		

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01060	Continued From page 24 notice with the required content and lacked documentation the OOLTC was provided a written notification when R1 did not return to the facility. On November 30, 2023, at 10:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee did not provide a written emergency relocation notice to the resident or designated representative, and did not provide the notice to the OOLTC when the resident did not return within four days. LALD/CNS-C stated the licensee was not aware of the requirements to provide the notice to the resident, designated representative, and the OOLTC and the content of the notice. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or	01330		

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01330	Continued From page 25 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one employee (unlicensed personnel (ULP)-A). 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: ULP-A was hired on February 16, 2023. ULP-A's record lacked evidence ULP-A was training and demonstrated competency as required. R1 was admitted February 18, 2023. R1's Home Health Aide Charting Sheet dated February 22, 2023, was identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as documented evidence of services provided to R1 by ULP-A. The services documented as provided by ULP-A included assistance with dressing, assistance with	01330		

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01330	Continued From page 26 hygiene, toileting assistance, homemaking, and medication reminder. On November 28, 2023, at 12:30 p.m., LALD/CNS-C stated ULP-A was not trained and found competent in the required areas prior to providing services to R1. LALD/CNS-C stated licensee was not aware of the required training and competencies per statute and was not provided to any employees. The licensee's 5.02 Competency Training Evaluations policy dated February 1, 2023, indicated all ULPs would be trained and would demonstrate competency in the statutorily required areas. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470		

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01470	Continued From page 27 and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-A, registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-A ULP-A was hired on February 16, 2023. ULP-A's Home Care Orientation Checklist dated February 16, 2023, indicated ULP-A completed all required orientation on the same day ULP-A was hired. ULP-A was orientated to 144A statutes, not the 144G statutes the licensee was required to operate under per their license. RN-B RN-B was hired on September 22, 2023. RN-B's Home Care Orientation Checklist dated September 31 (sic), 2023 (a date that does not exist), indicated RN-B was orientated to 144A statutes, not the 144G statutes the licensee was required to operate under per their license.	01470		

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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
01470	Continued From page 29 On November 28, 2023, at 1:10 p.m., RN-B stated they had not read or been trained on 144G Assisted Living statutes. RN-B stated they were aware of the statutes but were not familiar with the requirements. On November 28, 2023, at 1:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee was not aware of the difference between 144A and 144G statutes. Surveyor directed LALD/CNS-C to the Minnesota Legislature's Office of the Revisor of Statutes website to identify the difference between 144A Nursing Homes and Home Care statutes and 144G Assisted Living statutes the licensee was licensed to operate under. LALD/CNS-C was requested to provide content of the orientation classes documented as provided, but the licensee was not able to provide a class syllabus or objectives documented as provided to staff. LALD/CNS-C identified themselves as the owner of the assisted living facility, the person who applied for license issued September 13, 2022, and attested to understanding all 144G assisted living statutes and rules on licensee's application dated June 9, 2022. The licensee's 5.01 Orientation & Training policy dated February 1, 2023, indicated all staff would be orientated to the appropriate assisted living statutes and rules. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39303	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISE RESIDENTIAL SERVICES SC	8424 CLINTON AVENUE SOUTH BLOOMINGTON, MN 55420

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01650	Continued From page 30	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a service plan with all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01650		

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01650	Continued From page 31 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: R1 was admitted on February 18, 2023. R1's Home Health Aide Charting Sheet dated February 22, 2023, was identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as documented evidence of services provided to R1 by ULP-A. The services documented as provided by ULP-A included assistance with dressing, assistance with hygiene, toileting assistance, homemaking, and medication reminders. R1's Assessment As Of Date dated February 23, 2023, indicated R1 received services for medication management, activities of daily living (ADL), mobility assistance, assistance with safety, and management of behaviors related to R1's dementia diagnosis. On November 28, 2023, at 12:00 p.m., surveyor asked LALD/CNS-C for R1's service plan. LALD/CNS-C asked, "what exactly is on a service plan?" LALD/CNS-C held up R1's Home Health Aide Charting Sheet and asked surveyor, "Is this a service plan?" On November 28, 2023, at 12:15 p.m., surveyor directed LALD/CNS-C to licensee's own policy to review the contents of a service plan. Included with the policy, the licensee had an example	01650		

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01650	Continued From page 32 service plan for the licensee to copy and implement for each resident. LALD/CNS stated, "I have never seen that [service plan policy and service plan example]. I think the managers must have done that at my previous job." Registered nurse (RN)-B stated to LALD/CNS-C, "RTasks (an electronic health record computer system) will help us [licensee] develop the service plan. We will then need to sign it and have the resident sign it too." The licensee's 6.08 Service Plan policy dated February 1, 2023, indicated each resident would have a service plan with all required content developed and implemented with authentication by the resident or resident's designated representative. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650		
01910 SS=C	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910		

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01910	Continued From page 33 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a disposition of medications for one of one discharged resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 18, 2023, and discharged on February 23, 2023. R1's Medication Set Up Record dated for February 2023, indicated R1 received mediation administration from February 18, 2023, through February 22, 2023. R1's Assessment As Of Date dated February 23, 2023, indicated under the Medication section, R1 required medication administration and management due to cognitive deficits. R1's Discharge Medication document signed	01910		

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01910	Continued From page 34 February 23, 2023, by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C included a list of medications sent with R1's designated representative. The document failed to include the quantity of medications provided to R1's designated representative for 17 of the 20 medications listed. On November 28, 2023, at 12:30 p.m., LALD/CNS-C stated the licensee believed only controlled medications needed to be counted when discharged. LALD/CNS-C stated non-controlled medications were not counted completely, but all medication the licensee had were provided to R1's designated representative. The licensee's 7.23 Medication Disposal policy dated February 1, 2023, indicated when a resident who required medication management discharged from the licensee's care, the quantity of each medication would be documented and who/where the medications were given or disposed of. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090		

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03090	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect the current residents, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 9:50 a.m., the surveyor arrived at the licensee's facility and noted that no electronic monitoring notice was posted at the main entrance of the facility. On November 28, 2023, at 11:00 a.m. during a tour of the facility, an electronic monitoring sign was posted on the side of a filing cabinet in the common living area of the facility. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the sign was not posted at the main entrance as LALD/CNS-C was worried it may offend or bother neighbors. LALD/CNS-C stated the sign would be moved to the main entrance so anyone who entered the facility would be notified as required. No further information provided.	03090		

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03090	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *11/28/23*
Time: 08:35:10
Report: 1018231218

Food and Beverage Establishment Inspection Report

Location:
Rise Residential Services SC
8424 Clinton Ave S
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0042193
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH NO RESIDENTS AT THIS CURRENT TIME.

ALL FOOD IS PREPARED FOR SAME DAY AND NO COOLING HAPPENS IN THE FACILITY.

DISHWASHER HAS SANITIZE FUNCTION AND TEMPERATURE STICKER CONFIRMED APPROPRIATE TEMPERATURE WAS REACHED INSIDE THE MACHINE.

FLOORS, WALLS, CEILINGS AND EQUIPMENT ARE ALL RESIDENTIAL AND WILL BE MONITORED THROUGH THE YEARS.

DISCUSSED EMPLOYEE ILLNESS, ILLNESS REPORTING AND PEST CONTROL.

ESTABLISHMENT HAS 2 BASIN HAND SINK WITH ONE SIDE DESIGNATED FOR HAND WASHING ONLY.

Type: Full
Date: *11/28/23*
Time: 08:35:10
Report: 1018231218
Rise Residential Services SC

Food and Beverage Establishment Inspection Report

INSPECTION CONDUCTED WITH ANDREW SPAULDING (MDH) PRESENT.

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 1018231218 of 11/28/23.

Certified Food Protection Manager FARDOWSA A OMAR

Certification Number: FM114374 Expires: 07/18/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

FARDOWSA OMAR

Signed: _____

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