



HEALTH REGULATION DIVISION
NOTICE OF REVOCATION

In the Matter of RISE HOME HEALTH CARE LLC
547 Continental Drive
New Brighton, MN 55112

MDH HFID # **36117**

IT IS ORDERED that the Minnesota Department of Health ("Department" or "MDH") revokes the assisted living facility license for Rise Home Health Care (Rise), license number 420241 under the provisions of Minnesota Statutes Section 144G.20, subd. 1, as explained below.

Facts and Law:

1. Minn. Stat. § 144G authorizes the Department to regulate assisted living facilities in Minnesota. This authority includes issuing assisted living facility licenses, conducting surveys to determine compliance with the assisted living laws, and conducting complaint investigations of alleged violations of the assisted living facility laws. The Commissioner of Health is also authorized to revoke an assisted living facility license pursuant to Minn. Stat. § 144G.20, subd. 1 if certain conditions occur.
2. On August 1, 2021, MDH issued an assisted living facility license to Rise, HFID 36117, which was renewed most recently on February 1, 2025.
3. On March 3 to March 5, 2025, Department surveyors from the Health Regulation Division entered the Rise facility, HFID 36117, to conduct a survey under Minn. Stat. § 144G.30. The survey findings resulted in twenty-four (24) total correction orders, with two (2) correction orders had Level 3 findings.
 - a. A Level 3 citation is a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death.
4. On May 27 to May 29, 2025, Department surveyors from the Health Regulation Division entered the Rise facility, HFID 36117, to conduct a (license order) follow-up survey (LOF) under Minn. Stat. § 144G.30 to determine if Rise corrected deficient issues and systems identified during the March 3 to March 5, 2025, survey.
5. As a result of the May 27 to May 29, 2025, LOF, MDH determined the facility violated Minn. Stat. § 144G.30, subd. 5(c), when the licensee/owner did not document in the facility's records actions taken to comply with the correction orders issued during the March 3 to March 5, 2025, survey. Additionally, the facility had not demonstrated sufficient corrective action.
 - a. Eighteen (18) of twenty-four (24) correction orders were re-issued at the time of the LOF.

- b. During the original survey on March 3 to 5, 2025, MDH determined the licensee did not have sufficient documentation of action taken to comply with two (2) correction orders issued during a survey completed on July 7, 2022. As a result, the same two (2) correction orders were reissued during the original survey. During the May 27 to 29, 2025, LOF, MDH determined the same two (2) correction orders were still uncorrected and issued them again.
 - c. During the LOF on May 27 to May 29, 2025, the licensee did not have sufficient documentation of actions taken to comply with the correction orders that were issued during the survey which MDH conducted from March 3 to March 5, 2025.
 - d. As a result of the May 27, 2025, LOF, MDH issued twenty-two (22) new correction orders. In total, there were forty (40) correction orders issued from the LOF in May 2025. Nine (9) of the forty (40) correction orders were issued at a Level 3 (refer to definition above).
- 6. As a result of the May 27, 2025, LOF, MDH determined the licensee violated Minn. Stat. § 144G.41, subd. 1(13) when they did not provide staff access to an on-call registered nurse (RN) 24 hours per day, 7 days per week. On May 28, 2025, the facility's clinical nurse supervisor (CNS) told the surveyor she was currently on (maternity) leave and came in (on May 28, 2025) for her first day back specifically due to the LOF. She stated the licensed assisted living director (LALD)/RN was responsible for covering her duties in her absence.
 - a. Two (2) new residents moved into the facility on May 25, 2025. There was no nurse available for staff to call, seek direction from, or receive any information about the two new residents.
 - b. No assessment nor temporary service plan was completed for either resident.
 - c. On May 28, 2025, at 12:31 p.m., LALD/RN stated a family emergency prevented her from getting to the facility to complete the two (2) new resident admissions.
 - d. As of May 28, 2025, at 12:52 p.m., LALD/RN stated the (new) residents had not yet received any of their medications since admission.
 - e. On May 28, 2025, at 4:11 p.m., the owner stated he arranged for the two (2) residents to move into the facility on May 25, 2025, and notified LALD/RN, but because it was a holiday weekend it was difficult for their admissions to be completed.
- 7. As a result of the May 27, 2025, LOF, MDH determined the licensee violated Minn. Stat. § 144G.70, subd. 2(b) when the licensee did not ensure that an RN conducted a comprehensive nursing assessment of the physical, mental, and cognitive needs for two (2) residents. The initial resident assessment must be completed prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. A nursing assessment directly impacts the services offered/provided to the resident. It also influences which tasks are delegated by the RN to the unlicensed personnel (ULP) to perform.
 - a. Resident (R)4 and R5 both moved into the facility on May 25, 2025. Neither resident had a nursing assessment completed prior to the date they moved in

nor on the day they moved in. Both residents were also receiving assisted living services.

- b. R4's record contained a form titled, "Support Plan," dated November 26, 2024, completed by R4's county waived services case manager. The form indicated R4 had a diagnosis of "stroke". It further indicated R4 was nonverbal, and bed or wheelchair bound. The form also depicted R4 required assistance with meals/eating; dressing; bathing; grooming; mobility/wheeling wheelchair; transferring/positioning; medication management; clinical monitoring; and behavioral support.
 - c. R4's record also contained a form titled, "After Visit Summary," from a clinic dated, March 1, 2024. The form provided dietary instructions for "easy to chew" food and "thin liquids".
 - d. R5's record contained a form titled, "Home Health Certification and Plan of Care," dated May 22, 2025, and signed by R5's medical provider. The form indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It further indicated R5 required 24-hour supervision due to disorganization and wandering. The form also depicted R5 required assistance with dressing; continence care; grooming; bathing; medication management; verbal and visual cues; exercise; and health related assistance.
 - e. On May 28, 2025, at 9:40 a.m., the CNS stated she had not yet conducted a comprehensive nursing assessment for R4 nor R5 since the admissions on May 25, 2025. The CNS stated she had five days after a resident was admitted to complete admission assessments, obtain signed orders, and "things like that." The CNS told the surveyor she was currently on (maternity) leave and came in (on May 28, 2025) for her first day back specifically due to the LOF. She stated the licensed assisted living director (LALD)/RN was responsible for covering her duties in her absence.
8. As a result of the May 27, 2025, LOF, MDH determined the facility violated Minn. Stat. § 144G.70, subd. 3 when the licensee did not create a temporary service plan, to be effective for no more than 72 hours when they began providing services to R4 and R5 without completing the nursing assessments as noted above under paragraph seven (7).
- a. On May 28, 2025, at 2:06 p.m., the surveyor observed two ULPs conduct a two-person transfer for R4 from bed to motorized wheelchair. R4 had contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints that can lead to chronic pain) bilaterally in their legs, arms, and hands. The ULPs positioned R4 in the wheelchair and attempted to straighten R4's arms and legs causing R4 to moan, yell, and express facial grimacing consistent with pain. The surveyor observed R4 throughout the day and observed ULPs provide additional services and cares for R4, including a change of clothing and disposable brief; making a blended meal; and feeding R4. These services were all provided without a service plan in place.
 - i. A ULP used a blender to combine and blend salmon, vegetables, and a lettuce salad all together, and then fed it to R4.

- ii. The ULPs were unable to provide the surveyor with any specific instructions for R4's care needs. There were no instructions to unlicensed staff about how a transfer should be performed without a lift device; if his food needed to be blended all together; and when or how often to change his incontinence brief or reposition R4.
 - b. On May 25, 2025, R5 was also observed throughout the day. R5 walked throughout the facility. The ULPs prepared a meal for R5; provided general assistance; and redirection for "wandering behaviors". There was no service plan in place to further direct any cares or services.
9. As a result of the May 27, 2025, LOF, MDH determined the facility violated Minn. Stat. § 144G.71 when the licensee did not include in a service plan a written statement of the medication management services they were going to provide for R4 and R5; and when the nurse did not develop an individualized medication management plan for R4 and R5 (prior to ULPs administering medications to R5).
- a. R4's record did not contain prescriber orders for medications or treatments. R4 had no medications available to them at the facility and had not received their medications since just prior to their arrival to the facility on May 25, 2025. The licensee had no written direction available to the unlicensed personnel regarding R4's care needs nor medication requirements.
 - b. On May 27, 2025, at 11:26 a.m., via telephone, LALD/RN stated she was not aware of R4's status or medication needs. LALD/RN stated she did not think R4 had any medication at the facility.
 - c. On May 28, 2025, at 9:38 a.m., LALD/RN stated R4 had no medications (and R5, mentioned below, had two medications).
 - d. On May 28, 2025, at 12:03 p.m., via telephone, R4's county case manager stated R4 was supposed to be receiving, in addition to some other medications, Baclofen (a medication used to treat muscle spasms, stiffness, and tightness caused by conditions including multiple sclerosis, spinal cord injury, cerebral palsy, meningitis, and motor neuron disease) three times a day; and Tylenol as needed.
 - e. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 had contractures in bilaterally in his legs, arms, and hands. R4 was non-verbal and was unable to make his needs known. The two ULPs lifted R4 from each side putting one of their arms under his thighs and the other under his armpits and around his back. R4 made moaning and yelling sounds and had distressed facial expressions consistent with signs of pain or discomfort.
 - f. R5's record did not contain prescriber orders for medications or treatments. R5 had no medications available to them at the facility and had not received his medications since just prior to his arrival to the facility on May 25, 2025. The licensee had no written direction available to the ULPs regarding R5's care needs nor medication requirements.
 - g. R5's record contained a form titled, "Home Health Certification and Plan of Care," dated May 22, 2025, and signed by R5's medical provider. The form indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive

dyskinesia and post-traumatic stress disorder (PTSD). It further indicated R5 required 24-hour supervision due to disorganization and wandering. The document also indicated R5 took quetiapine (an antipsychotic medication used to treat a variety of mental health conditions, for example in Schizophrenia it helps manage symptoms like hallucinations and delusions), 200mg, one tablet at bedtime; and quetiapine 25mg, one tablet up to three times daily PRN for agitation.

- h. On May 28, 2025, at 9:38 a.m., the CNS stated she had not been to the facility for the last three months as she was on maternity leave. The CNS stated she was not aware of R4 and R5's admission and said, "I was asked to come in today, and I came in to learn more about them [referring to R4 and R5] today because you [the surveyors] were here."
 - i. On May 28, 2025, at 9:54 a.m., LALD/RN stated she did not have any medication for R5. LALD/RN stated during the survey was the first time there was a nurse at the facility since the new resident admissions, therefore, no one had been available to put medication or treatment orders into the system; neither R4 or R5 had received any medication since their admission to the licensee. LALD/RN stated she was required to come in and go through the medications and the orders before putting the medications into the system and that she was supposed to request treatment and medication orders from R4's doctor but did not get that far yet.
 - j. On May 28, 2025, at 4:11 p.m., the owner stated he arranged for R4 and R5 to move into the facility on May 25, 2025. He stated LALD/RN was notified of the admissions, but it was on a weekend and holiday, so it was difficult for the admissions to be completed. LALD/RN stated she was the only nurse for the facility while the CNS was on maternity leave and did not have a backup nurse to assist her in the CNS's absence.
10. As a result of the May 27, 2025, LOF, MDH determined the facility violated Minn. Stat. § 144G.60, subd. 4 (a) when the licensee did not ensure the RN trained two newly hired ULPs on proper methods of medication administration nor competency check them before they administered medications to residents.
- a. Two ULPs (ULP-G and ULP-H) were hired to begin providing direct care to residents on May 25, 2025.
 - b. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor. ULP-H introduced himself and stated he was a new employee for the night shift. At 9:58 a.m., the surveyor observed ULP-H retrieve a preset pill box from the locked medication cabinet and bring it to a resident's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into the resident's hand and the resident took the pills. ULP-H told the surveyor he did not have a password to the computer so he would just tell the morning staff that the resident took their medications. ULP-H stated he did not know much about medications, and he did not do charting. ULP-H stated he worked at another homecare before, and he

knew the job. ULP-H was working independently with no other ULP in the facility during that observation.

- c. On May 27, 2025, at 10:00 a.m., day shift staff arrived. At 10:30 a.m., ULP-H came into the facility and was introduced to the surveyor as a new employee who was still in training. ULP-H was also working alone while in training and had not yet have a completed background study to work independently with residents.
- d. On May 27, 2025, at 11:30 a.m., LALD/RN stated ULP-G and ULP-H had not been trained officially, and there were no training documents or any demonstration of competency for either of them. LALD/RN stated ULP-H was not supposed to give medication to a resident as he did not have a background study completed. LALD/RN stated ULP-G was allowed to pass medications to residents. LALD/RN-D also stated ULP-G had worked with R4 before (in R4's prior home). and they started working for the licensee when R4 moved to the licensee.
- e. On May 27, 2025, at 1:03 p.m., a resident stated ULP-H had been working at the licensee for about a week or two and had been given medications by both ULP-G and ULP-H, however, at 1:37 p.m., ULP-G stated they do not give medications.

11. As a result of the May 27, 2025, LOF, MDH determined the facility violated Minn. Stat. § 144G.41 subd. 1 (11) (ii) when the licensee did not ensure two staff were available to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; or to ensure prompt and effective response to individual resident or facility emergencies.

- a. The May 2025 staffing schedule indicated one ULP was scheduled to work each 12-hour shift, (AM shift 8:00 a.m. to 8:00 p.m., and PM shift 8:00 p.m. to 8:00 a.m.).
- b. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor, introduced themselves, and stated they were a new employee. ULP-H stated they had worked the night shift alone on May 26, 2025, and confirmed the licensee had four residents in the building. The day shift ULP arrived at 10:00 a.m.
- c. On May 27, 2025, at 11:28 a.m., via telephone, LALD/RN stated they thought R4 used a Hoyer lift (medical device used to transfer individuals who have limited mobility between surfaces like beds, chairs, or wheelchairs) for transfers which required two staff persons to assist.
- d. On May 28, 2025, at 9:40 a.m., ULP-G stated R4's Hoyer lift was broken. CNS and ULP-G stated they had been transferring R4 with the use of two people without the Hoyer since R4's arrival to the facility on May 25, 2025.
- e. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in his hospital bed and motorized wheelchair. The surveyor observed one of the ULPs provided care and services for R4 alone when the care should have been performed by two people. Cares included a two-person transfer from the hospital bed to the wheelchair, and a two-person assist for change of clothing and incontinence brief.

- f. On May 28, 2025, at 1:11 p.m., LALD/RN stated only one ULP had worked on the night of May 27, 2025.
 - g. On May 28, 2025, at 4:11 p.m., LALD/RN stated they only had one ULP scheduled the night of May 28, 2025, and said R4 did not need to get out of bed so they did not need to schedule two ULPs.
12. As a result of the May 27, 2025, LOF, MDH determined the facility violated Minn. Stat. § 144G.60, subd.4(b) when the licensee did not ensure two new employees (ULPs) successfully completed training and demonstrated competency of nurse-delegated tasks.
- a. On May 27, 2025, at 11:30 a.m., LALD/RN stated ULP-G and ULP-H had not been trained officially. There were no training, orientation, or demonstration of competency documents for either ULP-G or ULP-H.
 - b. On May 28, 2025, at 2:06 p.m., the surveyor observed ULP-G and another ULP conduct a two person transfer for R4 from bed to motorized wheelchair. R4 had contractures in his bilateral legs, arms, and hands. The ULPs lifted R4, one on from each side, putting one of their arms under his thighs and the other under his armpits and around his back. R4 made moaning and yelling sounds and had distressed facial expressions consistent with signs of pain or discomfort. R4's right foot was entrapped between the hospital bed and bed rail while the ULPs lifted him causing him to call out in pain. The surveyors intervened to stop the transfer as R4's entrapped foot went unnoticed by the ULPs. The ULPs repositioned R4, then successfully transferred him into his wheelchair. The ULPs positioned R4 in his wheelchair and attempted to straighten his arms and legs causing him to moan, yell, and again express facial grimacing consistent with pain.
 - c. ULP-G and ULP-H's employee records lacked training and competency evaluation documentation to include the following required content:
 - i. observing, reporting, and documenting resident status;
 - ii. basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;
 - iii. reading and recording temperature, pulse, and respirations of the resident;
 - iv. recognizing physical, emotional, cognitive, and developmental needs of the resident;
 - v. safe transfer techniques and ambulation;
 - vi. range of motioning and positioning;
 - vii. administering medications or treatments as required; and other RN/professionally delegated tasks (e.g., monitor vital signs, catheter care, mechanical lifts, etc.).
13. As a result of the May 27, 2025, LOF, MDH determined the facility violated Minn. Stat. § 144G.91, subd. 4(a) when the licensee did not provide care and services for R4 based on accepted health care standards. There was no bed-rail assessment completed for R4.

- a. R4 had a diagnosis of stroke, was non-verbal, bedbound with contractures, and completely dependent upon caregivers (ULPs) for his cares and activities of daily living (ADLs).
 - b. Assessing durable medical equipment (DME), including its use, efficacy, and safety, is a health care standard nurses/licensees are expected to comply with. Minn. Rule 4659.0150 outlines the required content for a nursing assessment, which includes the requirement to assess mobility, including ambulation, transfers, and assistive devices. A bed rail (either hospital style or consumer product) is considered an assistive device.
 - c. On May 28, 2025, at 9:34 a.m., the surveyor observed R4 in his hospital bed which was set in the high position (also dangerous and leads to injury if a person falls from bed). The surveyor observed there was a half bed rail attached to the right side of the hospital bed positioned in the middle of the bed between the head of the bed and the foot of the bed. The surveyor wiggled and pulled on the bed rail, which moved and appeared to be attached loosely to the bed.
 - d. According to U.S. Food and Drug Administration (FDA) recommendations, the need for bed rails must be assessed on a "frequent, regular basis." At a minimum, this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition.
14. As a result of the May 27, 2025, LOF, MDH determined the facility violated Minn. Stat. § 144G.60, subd. 1 when the licensee did not complete the required background study (BGS) on ULP-H before he started providing unsupervised cares to the residents of the facility.
- a. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor. ULP-H introduced himself and stated he was a new employee. ULP-H stated he had worked the night shift on May 26, 2025, for the licensee and stated the licensee had four residents in the building.
 - b. On May 27, 2025, at 9:58 a.m., the surveyor observed ULP-H retrieve a preset pill box from the locked medication cabinet and bring it to a resident's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into the resident's hand, and the resident took the pills. ULP-H was working independently with no other ULPs in the facility during this observation.
 - c. On May 27, 2025, at 11:30 a.m., via telephone, LALD/RN stated ULP-H was not supposed to give medication to a resident as he did not have a BGS completed, and ULP-G was supposed to be with (provide supervision within eye-sight of) ULP-H. LALD/RN further stated ULP-H's BGS was not done because ULP-H did not have a social security number (SSN). LALD/RN stated ULP-BH only had a work permit currently, and they were planning to complete a BGS when ULP-H got his SSN.
15. In conclusion, as a result of the May 27, 2025, LOF, MDH determined the facility violated the law when the licensee did not demonstrate sufficient management, control, and operation of the housing and services provided by the facility. This failure was evident:

during the LOF, instead of improving and correcting previously issued orders, an additional twenty-two (22) new correction orders (on top of the prior uncorrected orders) were issued. In total, there were forty (40) correction orders issued from the LOF. Nine (9) of the forty (40) correction orders were issued at a level three.

[These violations are elaborated in the attached state form, enclosure 1.]

Current Status and Requirement for Transition Plan

This letter notifies you that MDH is revoking the assisted living facility license number 420241.

1. Pursuant to Minn. Stat. § 144G.20, subd. 12, within five business days of receipt of this notice, you are required to provide to MDH, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities the names of residents and the names and addresses of the residents' designated representatives and legal representatives, and family or other contacts listed in the assisted living contract. The controlling individual or designees of the facility must provide updated information each month until the proceeding is concluded. If the controlling individual or designee of the facility fails to provide the information within this time, the facility is subject to the issuance of a correction order a \$500 fine the first day of noncompliance and an increase in the \$500 fine by \$100 increments for each day the noncompliance continues.
2. **You may appeal this decision.**
 - a. Minn. Stat. § 144G.20, subd. 13 states you are entitled to a contested case hearing under Minn. Stat. § 14.57 to 14.69.
 - b. Minn. Stat. § 144G.20, subd. 18 states to appeal “an action against a license under this section, a licensee must request a hearing no later than 15 business days after the licensee receives notice of the action.”
3. The appeal must be made in writing by mail or delivered to MDH, per Minn. Stat. § 144G.20, subd. 14, and must contain “a brief and plain statement describing every matter or issue contested” and “a brief and plain statement of any new matter that the applicant or assisted living facility believes constitutes a defense or mitigating factor.”

The appeal can be submitted online to the HRD Appeals Submission Form (<https://forms.web.health.state.mn.us/form/HRDAppealsForm>) or mailed to the following address:

Reconsideration Unit, Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
625 Robert Street North
Saint Paul, MN 55155

4. Minn. Stat. § 144G.20, subd. 16 reads, “Within 15 business days of receipt of the licensee's timely appeal of a sanction under this section, other than for a temporary suspension, the commissioner shall request assignment of an administrative law judge. The commissioner's request must include a proposed date, time, and place of hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 90 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause or for purposes of discussing settlement. In no case shall one or more extensions be granted for a total of more than 90 calendar days unless there is a criminal action pending against the licensee.”
5. **If you do not request a hearing** within 15 business days of your receipt of this Notice, or if an appeal of the revocation is withdrawn or dismissed, this Notice will become the Commissioner’s order of revocation. You must provide MDH, county adult protection and case managers, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities, the information described in Minn. Stat. § 144G.20, subd. 15. MDH will then monitor your transfer plan. You are permitted to continue operating while residents are being transferred to other service providers. Your license will be closed upon completion of the transfer plan.
6. **Impact on issuance of other licenses:** Minn. Stat. § 144G.20, subd. 5 states that if a Minnesota assisted living facility license is “revoked because of noncompliance with applicable laws or rules,” then the owner and managerial officials of that assisted living facility “shall not be eligible to apply for nor will be granted an assisted living facility license under this chapter or a home care provider license under chapter 144A, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, for five years following the effective date of the nonrenewal or revocation. If the owners or managerial officials already have enrollment status, the Department of Human Services shall terminate that enrollment.”

Further, Minn. Stat. § 144G.20, subd. 5 (c) indicates “the commissioner shall not renew, or shall suspend or revoke, the license of a facility that includes any individual as an owner or managerial official who was an owner or managerial official of a facility whose license in this state, or any other state was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.”

Issuance of Survey Results / No Limited Authority:

MDH will continue to conduct any surveys or investigations already initiated and may issue correction orders to Rise Home Health Care, Inc as well as maltreatment determinations under Minn. Stat. § 626.557. Based on the results of those findings, or on the results of any additional complaint investigations which may be initiated, or on the results of any other inspection

conducted by MDH or another agency with appropriate jurisdiction, MDH may employ any of the enforcement tools listed in Minn. Stat. § 144G.20. This Order does not in any way or manner limit or affect the authority of MDH to proceed against the facility or any employee of the facility, based on any act, conduct or admission that justifies that action, whether it occurred before or after the date of this Order.

MARIA KING
DIVISION DIRECTOR

**MINNESOTA DEPARTMENT OF HEALTH
HEALTH REGULATION DIVISION**

Maria King Digitally signed by Maria King
Date: 2025.07.23 09:03:10
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Maria King, RN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36117016-1 On May 27, 2025, through May 29, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 5, 2025. At the time of the survey, there were four residents; four receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/ or issued. An immediate correction order was identified on May 27, 2025, issued for SL36117016-1, tag identification 1750. An immediate correction order was identified on May 28, 2025, issued for SL36117016-1, tag identification 2310. Immediate correction orders were identified on May 28-29, 2025, issued for SL36117016-1, tag identifications 0470, 0495, 1290, 1610, and 1630. During the survey, the licensee took action to mitigate the immediate risks identified. However, noncompliance remained, and the scope and level remain unchanged.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 340} SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
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{0 340}	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (0470, 0680) for a survey completed on July 7, 2022, correction order (0470) following a complaint investigation concluded November 21, 2022, and correction orders (0340, 0345, 0470, 0550, 0580, 0680, 0790, 0800, 0910, 0950, 1290, 1470, 1500, 1530, 1640, 1730, 1750, 1760) for a survey completed on March 5, 2025. This had the potential to affect all residents, staff, and visitors at the facility.	{0 340}			

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{0 340}	Continued From page 2 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 28, 2025, surveyors conducted a follow-up survey on correction orders issued pursuant to a survey completed on March 5, 2025. Tag 0470 was originally issued during a July 7, 2022, survey. The tag was issued a second time following a complaint investigation concluded on November 21, 2022, and a third time following a survey concluded March 5, 2025. Tag 0680 was originally issued following the survey concluded July 7, 2022, and was issued a second time following the survey concluded March 5, 2025. On May 28, 2025, licensed assisted living director/registered nurse (LALD/RN)-D stated they had not done anything with the fire extinguisher and that the fire extinguisher on the main floor was still missing the inspection tag (tag 0790). LALD/RN-D further stated none of the maintenance throughout the facility had been completed (tag 0800). On May 29, 2025, at 9:20 a.m., LALD/RN-D stated they had not made all the necessary	{0 340}			

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{0 340}	Continued From page 3 corrections following the correction orders previously cited. LALD/RN-D stated, "I was going to make the corrections first and then write the plan." The licensee lacked documentation to indicate they took action to comply with correction orders previously cited on July 7, 2022, November 21, 2022, and March 5, 2025. Tags 0340, 0345, 0470, 0550, 0580, 0680, 0790, 0800, 0910, 0950, 1290, 1470, 1500, 1530, 1640, 1730, 1750, and 1760 were all re-issued. Please refer to the tag identification numbers for additional information. No further information was provided.	{0 340}			
{0 345} SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make available the most recent	{0 345}			

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{0 345}	Continued From page 4 plan of correction in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders, after a survey conducted March 3, 2025, through March 5, 2025. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). On May 29, 2025, at 9:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they had not made all the necessary corrections following the correction orders previously cited. LALD/RN-D stated, "I was going to make the corrections first and then write the plan." No further information was provided.	{0 345}			
0 420 SS=I	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced	0 420			

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0 420	Continued From page 5 by: Based on observation, interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective February 1, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes	0 420			

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0 420	Continued From page 6 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." Page four was electronically signed by the licensed assisted living director/registered nurse ((LALD/RN)-D) on January 15, 2025. As a result of this survey, the following orders were issued under 0340, 0345, 0420, 0470, 0495, 0500, 0510, 0550, 0580, 0630, 0680, 0730, 0780, 0790, 0800, 0900, 0910, 0950, 1290, 1320, 1330, 1460, 1470, 1500, 1530, 1610, 1630, 1640, 1730, 1750, 1760, 1770, 1820, 1830, 1910, 1940, 1950, 1960, 1970, and 2310. Correction orders 0470, 0495, 1290, 1610, 1630, 1750, and 2310 were issued with an immediate time period for correction during the survey. This 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
{0 470} SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet	{0 470}			

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{0 470}	Continued From page 7 the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that two personnel were available 24 hours per day, seven days per week, to meet the scheduled and reasonably foreseeable unscheduled needs of each resident and to ensure the facility could respond promptly and effectively in the event of an emergency. Additionally, the licensee failed post their daily staffing schedule. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was	{0 470}			

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{0 470}	Continued From page 8 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: SUFFICIENT STAFFING The licensee held an assisted living facility license. The facility was licensed for a capacity of four residents, and during the survey had a census of four residents. The licensee's employee schedule for the month of May 25, thorough May 31, 2025, indicated one unlicensed personnel (ULP) was scheduled to work each 12-hour shift, (AM shift 8:00 a.m., to 8:00 p.m., and PM shift 8:00 p.m., to 8:00 a.m.). The employee schedule did not include ULP-H or ULP-G. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor. ULP-H introduced themselves and stated they were a new employee. ULP-H stated they had worked the night shift on May 26th for the licensee and stated the licensee had four residents in the building. On May 27, 2025, at 9:58 a.m., the surveyor observed ULP-H perform medication administration for R3. ULP-H was working independently with no other ULP in the facility during this observation. On May 27, 2025, at approximately 10:00 a.m., ULP-A arrived at the licensee and stated they were a day shift personnel.	{0 470}			

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{0 470}	Continued From page 9 R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. On May 27, 2025, at 11:28 a.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated they thought R4 used a Hoyer lift for transfers with a two person assist. On May 28, 2025, at 9:40 a.m., ULP-G stated R4's Hoyer lift was broken. Clinical nurse supervisor (CNS)-C and ULP-G stated they had been transferring R4 with the use of two people without the Hoyer since their arrival to the facility on May 25, 2025. On May 28, 2025, at 9:50 a.m., LALD/RN-D stated on the night of May 26, 2025, into May 27, 2025, O/ULP-J worked overnight with ULP-H. O/ULP-J left at 8:15 a.m., and ULP-A came in to work at 8:00 a.m. The surveyor informed LALD/RN-D that upon the surveyors' arrival at the facility at 9:35 a.m., there was only ULP-H working and ULP-A arrived at approximately 10:00 a.m. LALD/RN-D stated ULP-A forgot their phone at home and they went back to go get their phone from home. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed ULP provide services and	{0 470}			

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{0 470}	Continued From page 10 cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. On May 28, 2025, at 1:11 p.m., LALD/RN-D stated only one person, ULP-E, had worked on the night of May 27, 2025. On May 28, 2025, at 4:11 p.m., LALD/RN-D stated they one had one ULP scheduled the night of May 28, 2025. LALD/RN-D further stated R4 did not need to get out of bed so they did not need to schedule two ULPs. POSTINGS On May 27, 2025, at 9:45 a.m., the surveyor observed the facility lacked a posted staff schedule. On May 27, 2025, at 12:42 p.m., LALD/RN-D stated they were not at the facility this week and there was no one to post the schedule, the schedule had not changed, and the employees knew their schedules. The licensee's Staffing policy dated June 24, 2024, indicated the clinical nurse supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. The staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the	{0 470}			

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{0 470}	Continued From page 11 evaluation are documented in the meeting minutes. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	{0 480}			

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{0 480}	Continued From page 12 storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This had the	0 495	Not reviewed during this survey.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(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	
0 495	Continued From page 13 potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. R4's resident record lacked an assessment, service plan, or any record completed by the licensee. R4's record lacked prescriber orders for medications or treatments. R4 had no medications prescribed by their provider available to them and had not received their medications since their arrival to the facility on May 25, 2025. The licensee had no written direction available to the unlicensed personnel regarding R4's care needs or information in the event of an	0 495			

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0 495	Continued From page 14 emergency. On May 28, 2025, at 12:02 p.m., R4's case manager (CM) stated R4 took the following medications: -acetaminophen; -baclofen 10 milligrams (mg) three times daily for muscle spasms; -lactose reduced Ensure; -mineral oil for skin; -Miralax; and -senna. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed unlicensed personnel (ULP) provide (nurse-delegated) services and cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. R5 R5 was admitted to the licensee on May 25, 2025. R5's Home Health Certification and Plan of Care form signed by R5's medical provider on May 22, 2025, indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It indicated R5 required 24-hour supervision due to disorganization and wandering. It indicated R5 required assistance	0 495			

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0 495	Continued From page 15 with dressing, continence care, grooming, bathing, medication management, verbal and visual cues, exercise and health related assistance. It indicated R5 took the following medications: -acetaminophen 500mg, one tablet every six hours as needed (PRN); -quetiapine 200mg, one tablet at bedtime; and -quetiapine 25mg, one tablet up to three times daily PRN for agitation. R5's resident record lacked an assessment, service plan, or any record completed by the licensee. R5 had no medications prescribed by their provider available to them and had not received their medications since their arrival to the facility on May 25, 2025. The licensee had no written direction available to the unlicensed personnel regarding R5's care needs or information in the event of an emergency. On May 28, 2025, the surveyor observed R5 throughout the day. The surveyor observed R5 wandering the facility, ULP meal preparation, R5 eating, general assistance, and redirection of wandering behaviors. On May 28, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-C stated they had not yet conducted a comprehensive assessment or bed rail assessment for R4 since their admission on May 25, 2025. CNS-C stated they had five days after a resident was admitted to complete admission assessments, obtain signed orders, and "things like that." CNS-C stated neither R4 or R5 had an assessment or service plan completed. CNS-C stated they were currently on maternity leave and May 28 was their first day back; they stated they only returned because of the survey. CNS-C stated licensed assisted living	0 495			

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0 495	Continued From page 16 director/registered nurse (LALD/RN)-D was covering for them to complete nursing duties in their absence. On May 28, 2025, at 12:31 p.m., LALD/RN-D stated they had not completed R4 or R5's admission assessments, service plans, medication ordering, or any other items required for an admission. LALD/RN-D stated a family emergency prevented them from getting to the facility to take care of R4 and R5's admissions. LALD/RN-D stated since R4 and R5 were admitted on May 25, 2025, they still had a few days to complete their admission; they stated they normally try to complete the admission process within five days after a resident was admitted. LALD/RN-D stated they did not have a backup nurse while CNS-C was on maternity leave, so they were the only nurse for the licensee. On May 28, 2025, at 12:52 p.m., LALD/RN-D stated R4 and R5 had not taken any medications since they were admitted to the facility. LALD/RN-D stated they had not been to the facility since R4 and R5 were admitted (until during the survey on May 28). LALD/RN-D stated they did not know what medications R4 and R5 were supposed to be taking. LALD/RN-D stated they were planning on addressing both residents' medication needs today during the survey. On May 28, 2025, at 2:42 p.m., owner/unlicensed personnel (O/ULP)-J stated R4 and R5 were supposed to be admitted to the licensee on May 9, 2025, but the family did not physically bring them to the facility until May 25, 2025. LALD/RN-D stated they were trying their best to complete admission assessments within five days of a resident's admission. The surveyor explained	0 495			

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0 495	Continued From page 17 to LALD/RN-D and CNS-C they did not have five days to complete a new resident's admission, they were required to complete a resident's admission assessment on, or before, the date of admission. LALD/RN-D and CNS-C stated they did not know the statute requirement. On May 28, 2025, at 4:11 p.m., O/ULP-J stated he arranged for R4 and R5 to move into the facility on May 25, 2025. O/ULP-J stated LALD/RN-D was notified of the admission but it was on a weekend and holiday, so it was difficult for their admission to be completed. LALD/RN-D stated they were the only nurse for the facility while CNS-C was on maternity leave and did not have a backup nurse to assist them in CNS-C's absence. The licensee's Staffing Plan dated April 15, 2025, indicated a registered nurse supervisor would be available, "Hours: 24/7 coverage, 12-hour shifts or 8-hour shifts depending on the staffing model." The licensee's Assessment and Reassessment policy dated June 24, 2024, indicated, "2. The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery." It further indicated, "12. Assessments are available on weekends and holidays." On May 29, 2025, at 10:35 a.m., LALD/RN-D stated they did not have a policy to address nurse	0 495			

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0 495	Continued From page 18 staffing requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control	0 500			

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0 500	Continued From page 19 and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's renewal "Application for Assisted Living License", section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable	0 500			

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0 500	Continued From page 20 section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be	0 500			

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0 500	Continued From page 21 classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page four was electronically signed by licensed assisted living director/registered nurse (LALD/RN)-D on January 15, 2025. The licensee had an assisted living license issued on February 1, 2025, with an expiration date of January 31, 2026. The licensee failed to ensure the following policies and procedures were implemented: - conducting and handling background studies on employees; - orientation, training, and competency	0 500			

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0 500	Continued From page 22 evaluations of staff, and a process for evaluating staff performance; - delegation of tasks by registered nurses or licensed health professionals; - conducting initial evaluations of residents' needs and the providers' ability to provide those services; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, communicated to staff and other health care providers as appropriate; - infection control practices; - orientation to and implementation of the assisted living bill of rights; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510			

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0 510	Continued From page 23 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care or medical and nursing standards for infection control related to hand hygiene. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was a split-level home; it had one main floor bathroom and one basement bathroom. On May 28, 2025, at 9:10 a.m., the surveyor observed the upstairs bathroom lacked paper towels for hand drying. Licensed assisted living director/registered nurse (LALD/RN)-D told the surveyor to use the paper towels on the kitchen counter. The surveyor observed the paper towels	0 510			

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0 510	Continued From page 24 were behind a bowl of apples and oranges and would have to be reached across with wet hands to get a paper towel. On May 28, 2025, at 9:20 a.m., the surveyor observed the upstairs bathroom which lacked paper towels for hand drying. The surveyor observed the vanity was wet with standing water on the counter surrounding the sink. The surveyor observed the bathroom garbage contained wads of moist toilet paper. On May 28, 2025, at 9:26 a.m., the surveyor observed the downstairs bathroom lacked paper towels for hand drying. The surveyor observed a quarter of a roll of toilet paper on the corner of the vanity immediately next to the sink; the end of the roll was moist in various places of the toilet paper. On May 28, 2025, at 9:33 a.m., the surveyor observed paper towels had been put in the upstairs bathroom by facility staff. On May 28, 2025, at 12:41 p.m., the surveyor observed the downstairs bathroom lacked paper towels for hand drying and still had the quarter roll of toilet paper on the vanity. On May 29, 2025, at 8:45 a.m., the surveyor observed the downstairs bathroom lacked paper towels for hand drying; toilet paper was no longer on the vanity. On May 29, 2025, at 11:00 a.m., R3 stated the bathrooms were frequently without paper towels so they used toilet paper. On May 29, 2025, at 11:10 a.m., LALD/RN-D stated they had plenty of paper towels and aides (unlicensed personnel) should be replacing them	0 510			

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0 510	Continued From page 25 when they were out. The Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers webpage, last updated on February 27, 2024, indicated: "Know how to wash hands with soap and water 1. Wet hands with water. 2. Apply the manufacturer recommended amount of product to your hands. 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. 5. Avoid using hot water to prevent drying of the skin." Although requested, a hand washing policy was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting	{0 550}			

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{0 550}	Continued From page 26 suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Health Facility Complaints (OHFC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 27, 2025, at approximately 9:45 a.m., the surveyor observed contact information for the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center, posted on the wall by the living room. The surveyor observed the licensee lacked the contact information for: - OHFC. On May 29, 2025, at 9:22 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they printed the OHFC's contact	{0 550}			

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{0 550}	Continued From page 27 information, but they forgot to post it. No further information was provided.	{0 550}			
{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 activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	{0 580}			

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{0 580}	Continued From page 28 The findings include: On May 29, 2025, at 9:23 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the quality management meeting documentation dated February 15, 2021, provided during the last survey was the most recent documentation the licensee had for quality management activities. LALD/RN-D stated the licensee had not held a quality management meeting after the last survey. The licensee's Quality Improvement policy, dated June 24, 2024, indicated documentation of Quality Improvement activities would be maintained and updated as needed, but not less than annually. The licensee would maintain documented quality improvement program for at least for two years. No further information was provided.	{0 580}			
0 630 SS=E	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	0 630			

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0 630	Continued From page 29 by: Based on interview and record review, the licensee failed to provide an individual abuse prevention plan (IAPP) for two of four residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed unlicensed personnel (ULP) provide services and cares for R4 which included	0 630			

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0 630	Continued From page 30 a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. R5 R5 was admitted to the licensee on May 25, 2025. R5's Home Health Certification and Plan of Care form signed by R5's provider on May 22, 2025, indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It indicated R5 required 24-hour supervision due to disorganization and wandering. It indicated R5 required assistance with dressing, continence care, grooming, bathing, medication management, verbal and visual cues, exercise, and health related assistance. On May 28, 2025, the surveyor observed R5 throughout the day. The surveyor observed R5 wandering the facility, ULP meal preparation, R5 eating, general assistance, and redirection of wandering behaviors. R4 and R5's record lacked an IAPP to include an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of self-abuse; 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	0 630			

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0 630	Continued From page 31 vulnerable adults. On May 27, 2025, at 12:50 p.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated they did not do any paperwork including an assisted living contract, admission assessment, individual abuse prevention plan, medication management plan, treatment and therapy management plan, or a service plan for R4 and R5's admission since there was no nurse or LALD at the facility when the resident's moved in. On May 28, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated they had not been to the facility for the last three months as they were on maternity leave. CNS-C stated they were not aware of R4 and R5's admission. CNS-C stated, "I have not been here for the last three months; you guys [referring to the surveyors] came here yesterday and I was asked to come in today and I came in to learn more about them [referring to R4 and R5] today." On May 28, 2025, at 12:52 p.m., LALD/RN-D stated they had not been to the facility since R4 and R5 were admitted, and a family emergency prevented them from getting to the facility. On May 28, 2025, at 4:11 p.m., owner/unlicensed personnel (O/ULP)-J stated he arranged for R4 and R5 to move into the facility on May 25, 2025. O/ULP-J stated LALD/RN-D was notified of the admission but it was on a weekend and holiday, so it was difficult for their admission to be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630			

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0 630	Continued From page 32 days	0 630			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain an emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post the EPP in a prominent area. This had the potential to affect all residents, staff, and visitors.	{0 680}			

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{0 680}	Continued From page 33 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: The licensee's undated Emergency Preparedness plan lacked evidence of the following required content: - patient population; - all hazard assessment; - policies and procedures for medical documents; - development of communication plan and annual review of the plan; - methods of sharing information; - sharing information on occupancy/needs; - communication plan including all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, and volunteers; - communication plan must include contact information for the following: Federal, State, tribal, regional & local EP staff, state licensing and certification agency, Office of Ombudsman for Long-Term Care; - annual review of the EPP; and - quarterly review of missing resident. On May 29, 2025, at 9:25 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did try to fix the EPP after the last survey, but they did not get through all of it.	{0 680}			

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{0 680}	Continued From page 34 The licensee's Emergency Preparedness policy dated June 24, 2024, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated June 24, 2024, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly and changes to the plan will be documented. Minnesota Administrative Rule 4659.0110, Subp 4. dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided.	{0 680}			
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;	0 730			

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0 730	Continued From page 35 (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received 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 provide a discharge summary with required content for one of one resident discharged from the licensee (R1). In addition, the licensee failed to produce required contents of resident records for two of two newly admitted residents (R4, R5).	0 730			

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0 730	Continued From page 36 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: DISCHARGED RESIDENT R1 R1 was admitted to the licensee on October 15, 2020, and received assisted living services. R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with dressing, haircare, grooming, toileting, bathing, medication reminders, treatment and exercise reminders, medication administration, hands-on assistance with transfers and mobility, personal laundry, housekeeping and linen change, and I am ok check service. The licensee's Discharge or Deceased Resident Roster dated July 5, 2022 [sic] indicated R1 was admitted to the licensee on August 20, 2023, and discharged on May 24, 2025. R1's record lacked a discharge summary to include the following required information: - a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the	0 730			

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0 730	Continued From page 37 latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; - a reconciliation of all predischage medications with the resident's post discharge prescribed and over-the-counter medications; and - a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On May 27, 2025, at 12:49 p.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated R1 was moved to a new facility owned by the licensee's owner. LALD/RN-D stated they did not do any discharge paperwork for R1 as they had not been at the facility during or after the discharge. On May 28, 2025, at 2:15 p.m., LALD/RN-D stated they were not sure whether it was considered discharge or transfer since R1 was moved to a different facility under the same ownership. LALD/RN-D also stated they sent R1's medication with R1 to the new facility but they did not do medication disposition documentation. NO RESIDENT RECORDS R4 R4 was admitted to the licensee on May 25, 2025.	0 730			

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0 730	Continued From page 38 R4's Department of Human Services (DHS) Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed unlicensed personnel (ULP) provide services and cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. The only documents the licensee could produce for R4 were an After Visit Summary (AVS) from a February 27, 2024-March 1, 2024, hospitalization and the Support Plan dated November 26, 2024. The AVS contained the following components of the required information: - the resident's name; and - names, addresses, and telephone numbers for health and medical service providers. The Support Plan contained the following	0 730			

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0 730	Continued From page 39 components of the required information: - identifying information, including the resident's name, date of birth, telephone number; and the licensee's name (listed as a place where R4 receives 24-hour customized living services); and - some medical history. R4's record lacked the following components of the required contents of resident records: (1) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (2) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (3) the resident's advance directives, if any; (4) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (5) the facility's current and previous assessments and service plans; (6) all records of communications pertinent to the resident's services; (7) 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; (8) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (9) documentation that services have been provided as identified in the service plan; (10) documentation that the resident has received and reviewed the assisted living bill of rights; (11) documentation of complaints received and any resolution;	0 730			

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0 730	Continued From page 40 (12) a discharge summary, including service termination notice and related documentation, when applicable; and (13) other documentation required under this chapter and relevant to the resident's services or status. R4's resident record lacked an assessment, service plan, or any record completed by the licensee. The licensee had no written direction available to the unlicensed personnel regarding R4's care needs or information in the event of an emergency. R5 R5 was admitted to the licensee on May 25, 2025. R5's Home Health Certification and Plan of Care form signed by R5's provider on May 22, 2025, indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It indicated R5 required 24-hour supervision due to disorganization and wandering. It indicated R5 required assistance with dressing, continence care, grooming, bathing, medication management, verbal and visual cues, exercise and health related assistance. On May 28, 2025, the surveyor observed R5 throughout the day. The surveyor observed R5 wandering the facility, ULP meal preparation, R5 eating, general assistance, and redirection of wandering behaviors. The only documents the licensee could produce for R5 were an AVS dated November 26, 2024, from an oral surgery clinic, DHS Support Plan dated April 7, 2025, and the Home Health	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
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0 730	Continued From page 41 Certification and Plan of Care form dated May 22, 2025. The AVS contained the following components of the required information: - identifying information, including the resident's name, date of birth, address, and telephone number; - names, addresses, and telephone numbers of the resident's health and medical service providers; and - health information including allergies, and medication list. The Support Plan contained the following components of the required information: - identifying information, including the resident's name, and the licensee's name (listed as provider). The Home Health Certification and Plan of Care contained the following components of the required information: - identifying information, including the resident's name, date of birth, address, and telephone number; and - health information, including medical history, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records. R5's record lacked the following components of the required contents of resident records: (1) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (2) the resident's advance directives, if any; (3) copies of any health care directives, guardianships, powers of attorney, or conservatorships;	0 730			

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0 730	Continued From page 42 (4) the facility's current and previous assessments and service plans; (5) all records of communications pertinent to the resident's services; (6) 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; (7) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (8) documentation that services have been provided as identified in the service plan; (9) documentation that the resident has received and reviewed the assisted living bill of rights; (10) documentation of complaints received and any resolution; (11) a discharge summary, including service termination notice and related documentation, when applicable; and (12) other documentation required under this chapter and relevant to the resident's services or status. R5's resident record lacked an assessment, service plan, or any record completed by the licensee. The licensee had no written direction available to the unlicensed personnel regarding R5's care needs or information in the event of an emergency. On May 27, 2025, at 12:50 p.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated they did not do any paperwork including an assisted living contract, admission assessment, individual abuse prevention plan, medication management plan,	0 730			

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0 730	Continued From page 43 treatment and therapy management plan, or service plan for R4 and R5's admission since there was no nurse or LALD at the facility when the resident's moved in. On May 28, 2025, at 9:34 a.m., clinical nurse supervisor (CNS)-C stated they had not been to the facility for the last three months as they were on maternity leave. CNS-C stated they were not aware of R4 and R5's admission. CNS-C stated, "I have not been here for the last three months; you guys [referring to the surveyors] came here yesterday and I was asked to come in today and I came in to learn more about them [referring to R4 and R5] today." On May 28, 2025, at 9:38 a.m., LALD/RN-D stated normally when they admitted a new resident they asked for a recent after visit summary, case workers assessment of the resident, and health certification form, and then they would complete the uniform assessment tool, service plan, and other paperwork within four days; based on the residents' background information. The surveyor inquired if they had gotten background information on R4 and R5. LALD/RN-D stated they did get background information from R4 and R5's family and the case worker, but they did not have any records, and they did not do the required official documentation for both residents. LALD/RN-D further stated R4 and R5's family communicated residents' needs to the licensee over the phone. R4's family communicated that R4 had stroke, was nonverbal, bed bound, needed pureed food, and total care. LALD/RN-D stated they did not have anything in writing other than AVS' for both residents and provided the surveyors with R4 and R5's AVS'.	0 730			

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0 730	Continued From page 44 On May 28, 2025, at 12:52 p.m., LALD/RN-D stated they had not been to the facility since R4 and R5 were admitted, they stated a family emergency prevented them from getting to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 45 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms in required locations. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 28, 2025, the surveyor conducted a follow-up survey with licensed assisted living director/registered nurse (LALD/RN)-D on orders issued pursuant to a follow-up survey completed on March 5, 2025. The following new deficiency was observed. The smoke alarms directly outside of the bedrooms on first floor and in the basement were missing. LALD/RN-D stated that they were beeping when they arrived at the facility in the morning and that they had directed one of their staff to remove them so they could be replaced with new smoke alarms. Smoke alarms shall be provided outside each separate sleeping area in the immediate vicinity of bedrooms. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			

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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 maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 28, 2025, the surveyor conducted a follow-up survey with licensed assisted living director/registered nurse (LALD/RN)-D on orders issued pursuant to a follow-up survey completed on March 5, 2025. The following was observed.	0 790			

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0 790	Continued From page 47 The fire extinguisher located on the first floor was missing the service tag indicating that the fire extinguisher has received the annual service. Records for manual inspections shall be kept on a tag or label attached to the fire extinguisher.	0 790			
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect more than a limited number of 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{0 800}			

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{0 800}	Continued From page 48 The findings include: On May 28, 2025, the surveyor conducted a follow-up survey with licensed assisted living director/registered nurse (LALD/RN)-D on orders issued pursuant to a follow-up survey completed on March 5, 2025. The following was observed. - A door was installed between occupied resident bedroom 1 and the attached garage. When ULP-E opened the door, this door did not self-close and positively latch. - The handrail was loose, and one rail bracket had become disconnected for the stairs leading from basement bedroom 1 into the attached garage. - The bottom of the door was chipped and peeling for the shared resident bathroom in the basement. - In the basement laundry/mechanical room: - The sliding door was off the track. - One section of drywall was water damaged. - The carpet on the front steps was peeling, creating a trip/fall hazard. During the facility tour interview, LALD/RN-D verified the above listed physical environment observations.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	{0 810}			

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{0 810}	Continued From page 49 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: 0 900 SS=F 144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of:	{0 810}			
		0 900	Not reviewed during this survey.		

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0 900	Continued From page 50 (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop and execute a written assisted living contract with the required content for two of two newly admitted residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 900			

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0 900	Continued From page 51 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed unlicensed personnel (ULP) provide services and cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. R5 R5 was admitted to the licensee on May 25, 2025.	0 900			

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0 900	Continued From page 52 R5's Home Health Certification and Plan of Care form signed by R5's provider on May 22, 2025, indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It indicated R5 required 24-hour supervision due to disorganization and wandering. It indicated R5 required assistance with dressing, continence care, grooming, bathing, medication management, verbal and visual cues, exercise, and health related assistance. On May 28, 2025, the surveyor observed R5 throughout the day. The surveyor observed R5 wandering the facility, ULP meal preparation, R5 eating, general assistance, and redirection of wandering behaviors. R4 and R5's record lacked a written contract with licensee's facility address, which included all of the terms concerning the provisions of the following as required: - housing; - assisted living services, whether provided directly by the licensee or by management agreement or other agreement; and - the resident's service plan, if applicable. In addition, R4 and R5's records lacked evidence that the contract had been fully executed as the licensee must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the licensee must offer the resident the	0 900			

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0 900	Continued From page 53 opportunity to identify a designated representative. On May 27, 2025, at 12:50 p.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated they did not do any paperwork including an assisted living contract, admission assessment, individual abuse prevention plan, medication management plan, treatment and therapy management plan, or service plan for R4 and R5's admission since there was no nurse or LALD at the facility when the resident's moved in. On May 28, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated they had not been to the facility for the last three months as they were on maternity leave. CNS-C stated they were not aware of R4 and R5's admission. CNS-C stated, "I have not been here for the last three months; you guys [referring to the surveyors] came here yesterday and I was asked to come in today and I came in to learn more about them [referring to R4 and R5] today." On May 28, 2025, at 12:52 p.m., LALD/RN-D stated they had not been to the facility since R4 and R5 were admitted, they stated a family emergency prevented them from getting to the facility. On May 28, 2025, at 4:11 p.m., owner/unlicensed personnel (O/ULP)-J stated he arranged for R4 and R5 to move into the facility on May 25, 2025. O/ULP-J stated LALD/RN-D was notified of the admission but it was on a weekend and holiday, so it was difficult for their admission to be completed. No further information was provided.	0 900			

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0 900	Continued From page 54	0 900			
{0 910} SS=C	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents with contracts (R2, R3). 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 the residents). The findings include: R2	{0 910}			

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NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
(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
{0 910}	Continued From page 55 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's Assisted Living Contract signed on July 8, 2022, lacked the following required content: - in a conspicuous place and manner on the contract the legal name and Health Facility Identification number (HFID#) of the licensee; and - name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. R3 R3 was admitted to the licensee on September 12, 2023, and received assisted living services. R3's Assisted Living Contract signed on September 12, 2023, lacked the following required content: - in a conspicuous place and manner on the contract the legal name and Health Facility Identification number (HFID#) of the licensee; and - name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the licensee of the facility; (2) the managing agent of the facility, if applicable; and (3) the authorized agent for the facility. On May 29, 2025, at 11:07 a.m., licensed assisted living director/registered nurse	{0 910}			

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{0 910}	Continued From page 56 (LALD/RN)-D stated they filled out the facility information on R3's assisted living contract, but they did not complete the rest of the required information. LALD/RN-D stated they did not correct R2's assisted living contract information yet and stated they would fix it that day. No further information was provided.	{0 910}			
{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	{0 950}			

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{0 950}	Continued From page 57 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 include the required statutory language giving residents the right to identify a designated representative in writing in the contract and failed to provide the required verbatim notice on its own separate page for two of two residents (R2, R3). 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 the residents). The findings include: R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's Assisted Living Contract was signed on July 8, 2022. R3 R3 was admitted to the licensee on September 12, 2023, and received assisted living services. R3's Assisted Living Contract signed was on September 12, 2023. The licensee's Assisted Living Contract form utilized for the above listed residents lacked the	{0 950}			

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{0 950}	Continued From page 58 required verbatim "right to designate a representative for certain purposes" notice on a document separate from the contract. On May 29, 2025, at 11:08 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did remember discussing the citation with the surveyor on the last survey, but they had not corrected it yet. No further information was provided.	{0 950}			
{01290} SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human	{01290}			

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{01290}	Continued From page 59 Services (DHS)) for one of eight employees (unlicensed personnel (ULP)-H). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H was hired on May 25, 2025, to provide direct care services to residents. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor. ULP-H introduced themselves and stated they were a new employee. ULP-H stated they had worked the night shift on May 26th for the licensee and stated the licensee had four residents in the building. On May 27, 2025, at 9:58 a.m., the surveyor observed ULP-H retrieve a preset pill box from the locked medication cabinet and bring it to R3's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into R3's hand and R3 took the pills. ULP-H was working independently with no other ULP in the facility during this observation. On May 27, 2025, at 11:30 a.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated ULP-H was not supposed to give medication to a resident as he did not have a background study completed, and ULP-G was	{01290}			

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{01290}	Continued From page 60 supposed to be with ULP-H. LALD/RN-D further stated ULP-H's BGS was not done because ULP-H did not have social security number (SSN). LALD/RN-D stated ULP-H only had a work permit at the moment, and they were planning to run a BGS when ULP-H got their SSN. The licensee's NETstudy2.0 roster printed on May 27, 2025, did not include ULP-H in the list of employees with cleared BGS and affiliated to the licensee's health facility identification (HFID) 36117. The licensee's undated Background studies Policy indicated, "POLICY: Facility requires background screening to be completed on all employees, contractors, and regularly scheduled volunteers. Unwillingness to consent to the background study will result in withdrawal of the offer of employment. Results of the background studies are confidential and are retained in confidential employee files. Employees will not be able to start working with residents until the background check clearance has been received by the facility. PURPOSE: To provide a mechanism where background studies are completed on employees, contractors and volunteers To provide increased safety for residents of the Facility To reduce risk to the Facility" No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	{01290}			

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01320	Continued From page 61	01320			
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, 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 two of two newly hired employees (unlicensed personnel (ULP)-G, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01320			

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01320	Continued From page 62 The findings include: ULP-H was hired on May 25, 2025, to provide direct care services to residents. ULP-G was hired on May 25, 2025, to provide direct care services to residents. The licensee's employee schedule for the month of May 2025, did not include ULP-H or ULP-G. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor. ULP-H introduced themselves and stated they were a new employee. ULP-H stated they worked night shifts for the licensee and stated the licensee had four residents in the building. On May 27, 2025, at 9:58 a.m., the surveyor observed ULP-H retrieve a preset pill box from the locked medication cabinet and bring it to R3's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into R3's hand and R3 took the pills. ULP-H stated to the surveyor they did not have password to the computer so they would just tell the morning staff that R3 took their medications. ULP-H stated they did not know much about medications, and they did not do charting. ULP-H stated they were trained on how to change another resident, R4, by the licensee's other staff and they helped R4 to a chair with the morning shift ULP. ULP-H stated they worked at another homecare before, and they knew the job. ULP-H was working independently with no other ULP in the facility during the observation. On May 27, 2025, at approximately 10:00 a.m.,	01320			

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01320	Continued From page 63 ULP-A arrived at the licensee and stated they were a day shift personnel. On May 27, 2025, at 10:30 a.m., ULP-G came into the facility and ULP-A introduced ULP-G to the surveyor and stated ULP-G was a new employee and was still in training. On May 27, 2025, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated ULP-H and ULP-G had not been trained officially, and there were no training documents, no orientation or any demonstration of competency for either ULP. LALD/RN stated the clinical nurse supervisor (CNS)-C was on maternity leave since April 12, 2025, and LALD/RN-D had a sick child, so they were unable to provide any new hire orientation and training for the ULPs. On May 27, 2025, at 1:03 p.m., R3 stated ULP-H had been working at the licensee for about a week or two. R3 stated they had been given medications by both ULP-G and ULP-H. On May 27, 2025, at 1:37 p.m., ULP-G stated they give food to residents, they change and clean R4, but they do not give medications. On May 27, 2025, at 1:44 p.m., LALD/RN-D stated ULP-G and ULP-H were not included in the May work schedule as they (LALD/RN-D) did not get the chance to update the schedule and stated they would add the two new employees to the June work schedule. On May 28, 2025, at 2:06 p.m., the surveyor observed ULP-G and ULP-F conduct a two person transfer for R4 from their bed to their motorized wheelchair.	01320			

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01320	Continued From page 64 ULP-G and ULP-H's employee records lacked evidence of completed training and competency evaluation to include the following topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01320			

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01320	Continued From page 65 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320			
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 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 observation, interview, and record review, the licensee failed to ensure training was completed in all required areas for two of two newly hired employees (unlicensed personnel (ULP)-G, ULP-H). 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	01330			

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01330	Continued From page 66 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-H was hired on May 25, 2025, to provide direct care services to residents. ULP-G was hired on May 25, 2025, to provide direct care services to residents. The licensee's employee schedule for the month of May 2025, did not include ULP-H or ULP-G. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor. ULP-H introduced themselves and stated they were a new employee. ULP-H stated they worked night shifts for the licensee and stated the licensee had four residents in the building. On May 27, 2025, at 9:58 a.m., the surveyor observed ULP-H retrieve a preset pill box from the locked medication cabinet and bring it to R3's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into R3's hand and R3 took the pills. ULP-H stated to the surveyor they did not have password to the computer so they would just tell the morning staff that R3 took their medications. ULP-H stated they did not know much about medications, and they did not do charting. ULP-H stated they were trained on how to change another resident, R4, by the licensee's other staff and they helped R4 to a chair with the morning shift ULP. ULP-H stated they worked at another homecare before, and they knew the job.	01330			

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01330	Continued From page 67 ULP-H was working independently with no other ULP in the facility during the observation. On May 27, 2025, at approximately 10:00 a.m., ULP-A arrived at the licensee and stated they were a day shift personnel. On May 27, 2025, at 10:30 a.m., ULP-G came into the facility and ULP-A introduced ULP-G to the surveyor and stated ULP-G was a new employee and was still in training. On May 27, 2025, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated ULP-H and ULP-G had not been trained officially, and there were no training documents, no orientation or any demonstration of competency for either ULP. LALD/RN stated the clinical nurse supervisor (CNS)-C was on maternity leave since April 12, 2025, and LALD/RN-D had a sick child, so they were unable to provide any new hire orientation and training for the ULPs. On May 27, 2025, at 1:03 p.m., R3 stated ULP-H had been working at the licensee for about a week or two. R3 stated they had been given medications by both ULP-G and ULP-H. On May 27, 2025, at 1:37 p.m., ULP-G stated they give food to residents, they change and clean R4, but they do not give medications. On May 27, 2025, at 1:44 p.m., LALD/RN-D stated ULP-G and ULP-H were not included in the May work schedule as they (LALD/RN-D) did not get the chance to update the schedule and stated they would add the two new employees to the June work schedule.	01330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(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	
01330	Continued From page 68 On May 28, 2025, at 2:06 p.m., the surveyor observed ULP-G and ULP-F conduct a two person transfer for R4 from their bed to their motorized wheelchair. ULP-G and ULP-H's employee records lacked training and competency evaluation to include; (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; (7) administering medications or treatments as required; and other RN/professionally delegated tasks (e.g., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts, etc.). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be	01460			

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01460	Continued From page 69 completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensure requirements and regulations before providing assisted living services to residents for two of two newly hired employees (unlicensed personnel (ULP)-G, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01460			

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01460	Continued From page 70 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-H was hired on May 25, 2025, to provide direct care services to residents. ULP-G was hired on May 25, 2025, to provide direct care services to residents. The licensee's employee schedule for the month of May 2025, did not include ULP-H or ULP-G. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor. ULP-H introduced themselves and stated they were a new employee. ULP-H stated they worked night shifts for the licensee and stated the licensee had four residents in the building. On May 27, 2025, at 9:58 a.m., the surveyor observed ULP-H retrieve a preset pill box from the locked medication cabinet and bring it to R3's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into R3's hand and R3 took the pills. ULP-H stated to the surveyor they did not have password to the computer so they would just tell the morning staff that R3 took their medications. ULP-H stated they did not know much about medications, and they did not do charting. ULP-H stated they were trained on how to change another resident, R4, by the licensee's other staff and they helped R4 to a chair with the	01460			

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01460	Continued From page 71 morning shift ULP. ULP-H stated they worked at another homecare before, and they knew the job. ULP-H was working independently with no other ULP in the facility during this observation. On May 27, 2025, at approximately 10:00 a.m., ULP-A arrived at the licensee and stated they were a day shift personnel. On May 27, 2025, at 10:30 a.m., ULP-G came into the facility and ULP-A introduced ULP-G to the surveyor and stated ULP-G was a new employee and was still in training. On May 27, 2025, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated ULP-H and ULP-G had not been trained officially, and there were no training documents, no orientation or any demonstration of competency for either ULP. LALD/RN stated the clinical nurse supervisor (CNS)-C was on maternity leave since April 12, 2025, and LALD/RN-D had a sick child, so they were unable to provide any new hire orientation and training for the ULPs. On May 27, 2025, at 1:03 p.m., R3 stated ULP-H had been working at the licensee for about a week or two. R3 stated they had been given medications by both ULP-G and ULP-H. On May 27, 2025, at 1:37 p.m., ULP-G stated they give food to residents, they change and clean R4, but they do not give medications. On May 27, 2025, at 1:44 p.m., LALD/RN-D stated ULP-G and ULP-H were not included in the May work schedule as they (LALD/RN-D) did not get the chance to update the schedule and stated they would add the two new employees to	01460			

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01460	Continued From page 72 the June work schedule. On May 28, 2025, at 2:06 p.m., the surveyor observed ULP-G and ULP-F conduct a two person transfer for R4 from their bed to their motorized wheelchair. ULP-H and ULP-G's employee record lacked orientation to assisted living facility licensure requirements and regulations to include the following topics: (1) an overview of this chapter (144G.08 to 144G.95); (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 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	01460			

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01460	Continued From page 73 (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
{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 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	{01470}			

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{01470}	Continued From page 74 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a	{01470}			

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{01470}	Continued From page 75 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: CNS-C was hired on June 22, 2020, to provide oversight to direct care staff. CNS-C's employee records lacked evidence of orientation to assisted living regulations for the following topics: - review of provider's policies and procedures; - review of types of assisted living services the employee will provide and providers scope of license; - overview of assisted living statutes; and - consumer advocacy service. On May 29, 2025, at 9:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they had not made all the necessary corrections following the correction orders previously cited. LALD/RN-D stated, "I was going to make the corrections first and then write the plan." On May 29, 2025, at 11:40 a.m., LALD/RN-D stated CNS-C went on maternity leave shortly after the last survey and did not get the time to do any of the training the licensee was previously cited for. LALD/RN-D stated CNS-C went on maternity leave on April 12, 2025. The licensee had no documentation of a plan of	{01470}			

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{01470}	Continued From page 76 correction to indicate the rationale for CNS-C not having received the missing orientation training content following a survey conducted March 3, 2025, through March 5, 2025, or indication of a date in which it would be completed or that it would be completed upon their return. The licensee's Staff Orientation and Education policy dated June 24, 2024, indicated all staff providing assisted living services would be required to complete the organization's orientation program before providing direct care to residents. The policy did not include contents of the orientation. No further information was provided.	{01470}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	{01500}			

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{01500}	Continued From page 77 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at	{01500}			

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{01500}	Continued From page 78 least eight hours of annual training for each 12 months of employment for one of three employees (clinical nurse supervisor (CNS)-C). 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 the potential to affect a large portion or all of the residents). The findings include: CNS-C was hired on June 22, 2020, to provide oversight to direct care staff. CNS-C's employee record included the following annual training: - 0.75 hours of training on effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders completed on April 1, 2024. CNS-C's employee record lacked the following annual training topics completed within the last 12 months: - assisted living bill of rights last completed on August 1, 2023; - infection control techniques last completed on August 1, 2023; - principles of person-centered planning and service delivery last completed on August 1, 2023; and - vulnerable adult last completed on August 1, 2023.	{01500}			

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{01500}	Continued From page 79 On May 29, 2025, at 11:40 a.m., LALD/RN-D stated CNS-C went on maternity leave shortly after the last survey and did not get the time to do any of the training the licensee was previously cited for. LALD/RN-D stated CNS-C went on maternity leave on April 12, 2025. The licensee had no documentation of a plan of correction to indicate the rationale for CNS-C not having received the missing orientation training content following a survey conducted March 3, 2025, through March 5, 2025, or indication of a date in which it would be completed or that it would be completed upon their return. The licensee's Staff Orientation and Education dated June 24, 2024, indicated all staff providing assisted living services will complete at least eight hours of training for each 12 months of employment. No further information was provided.	{01500}			
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one	{01530}			

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{01530}	Continued From page 80 hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (clinical nurse supervisor (CNS)-C) received at least eight hours of initial dementia care training within 120 working hours of their employment start date, and two hours of dementia training annually. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01530}			

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NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(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	
{01530}	Continued From page 81 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 the potential to affect a large portion or all of the residents). The findings include: CNS-C was hired on June 22, 2020, to provide oversight to direct care staff. CNS-C's employee record included an Educare (online training platform) training document which indicated CNS-C had 0.75 hours of dementia training completed on October 28, 2020, 3.5 hours of dementia training completed on August 1, 2023, and 0.75 hours of dementia training completed in April, 2024, for a total of 5 hours which was 3 hours short of the required eight hours of dementia training required to be completed within 120 working hours of the CNS's employment start date. CNS-C's employee record also lacked 2 hours of annual dementia training in 2022, 1.25 hours in 2023 and 2024. On May 29, 2025, at 11:40 a.m., LALD/RN-D stated CNS-C went on maternity leave shortly after the last survey and did not get the time to do any of the training the licensee was previously cited for. LALD/RN-D stated CNS-C went on maternity leave on April 12, 2025. The licensee had no documentation of a plan of correction to indicate the rationale for CNS-C not having received the missing orientation training content following a survey conducted March 3, 2025, through March 5, 2025, or indication of a date in which it would be completed or that it	{01530}			

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{01530}	Continued From page 82 would be completed upon their return. The licensee's Dementia Education policy dated June 24, 2024, indicated supervisors of direct care employees will have at least eight hours of initial dementia training within 120 working hours of the employment start date; and two hours education on topics related to dementia care for each 12 months of employment. No further information was provided.	{01530}			
01610 SS=I	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a	01610			

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01610	Continued From page 83 comprehensive assessment on, or before, the date of admission for two of two newly admitted residents (R4, R5). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. R4's resident record lacked a comprehensive assessment completed by a RN on, or before, the date of admission. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed unlicensed personnel (ULP)	01610			

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01610	Continued From page 84 provide services and cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. R4's resident record lacked an assessment, service plan, or any record completed by the licensee. R4's record lacked prescriber orders for medications or treatments. R4 had no medications prescribed by their provider available to them and had not received their medications since their arrival to the facility on May 25, 2025. The licensee had no written direction available to the unlicensed personnel regarding R4's care needs or information in the event of an emergency. R5 R5 was admitted to the licensee on May 25, 2025. R5's Home Health Certification and Plan of Care form signed by R5's provider on May 22, 2025, indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It indicated R5 required 24-hour supervision due to disorganization and wandering. It indicated R5 required assistance with dressing, continence care, grooming, bathing, medication management, verbal and visual cues, exercise and health related assistance. R5's resident record lacked a comprehensive	01610			

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01610	Continued From page 85 assessment completed by a RN on, or before, the date of admission. On May 28, 2025, the surveyor observed R5 throughout the day. The surveyor observed R5 wandering the facility, ULP meal preparation, R5 eating, general assistance, and redirection of wandering behaviors. R5's resident record lacked an assessment, service plan, or any record completed by the licensee. The licensee had no written direction available to the unlicensed personnel regarding R5's care needs or information in the event of an emergency. On May 28, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-C stated they had not yet conducted a comprehensive assessment or bed rail assessment for R4 since their admission on May 25, 2025. CNS-C stated they had five days after a resident was admitted to complete admission assessments, obtain signed orders, and "things like that." CNS-C stated neither R4 or R5 had an assessment or service plan completed. CNS-C stated they were currently on maternity leave and May 28 was their first day back; they stated they only returned because of the survey. CNS-C stated licensed assisted living director/registered nurse (LALD/RN)-D was covering for them to complete nursing duties in their absence. The surveyor questioned how their unlicensed personnel (ULP) could effectively and safely provide cares for R4 and R5 if they had not conducted a nursing assessment or used the assessment to develop a service plan for the residents. CNS-C stated they were told the family for R4 had been teaching the ULPs how to care for R4.	01610			

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01610	Continued From page 86 On May 28, 2025, at 10:46 a.m., LALD/RN-D stated ULP-G and ULP-H both worked as a personal care assistant (PCA) with R4 and R5 for approximately six months prior to their arrival to the licensee on May 25, 2025. LALD/RN-D stated both ULPs were hired by the licensee when R4 and R5 moved to the facility on May 25, 2025, to help care for them. On May 28, 2025, at 12:31 p.m., LALD/RN-D stated they had not completed R4 or R5's admission assessments. LALD/RN-D stated a family emergency prevented them from getting to the facility to take care of R4 and R5's admissions. LALD/RN-D stated since R4 and R5 were admitted on May 25, 2025, they still had a few days to complete their admission; they stated they normally try to complete the admission process within five days after a resident was admitted. LALD/RN-D stated they did not have a backup nurse while CNS-C was on maternity leave, so they were the only nurse for the licensee. On May 28, 2025, at 12:52 p.m., LALD/RN-D stated they had not been to the facility since R4 and R5 were admitted, they stated the family emergency prevented them from getting to the facility. On May 28, 2025, at 2:06 p.m., the surveyor observed ULP-G and ULP-F conduct a two person transfer for R4 from their bed to their motorized wheelchair. R4 had contractures in his bilateral legs, arms, and hands. The ULPs lifted R4 from each side putting one of their arms under his thighs and the other under his armpits and around R4's back. R4 made moaning and yelling sounds and had distressed facial expressions consistent with signs of pain or discomfort. R4's	01610			

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01610	Continued From page 87 right foot was entrapped between their hospital bed and bed rail while the ULPs lifted R4 causing R4 to call out in pain. The surveyors intervened to stop the transfer as R4's foot went unnoticed by the ULPs. The ULPs repositioned R4 then successfully transferred R4 into their wheelchair. The ULPs positioned R4 in their wheelchair and attempted to straighten R4's arms and legs causing R4 to moan, yell, and again express facial grimacing consistent with pain. On May 28, 2025, at 2:42 p.m., owner/unlicensed personnel (O/ULP)-J stated R4 and R5 were supposed to be admitted to the licensee on May 9, 2025, but the family did not physically bring them to the facility until May 25, 2025. LALD/RN-D stated they were trying their best to complete admission assessments within five days of a resident's admission. The surveyor explained to LALD/RN-D and CNS-C they did not have five days to complete a new resident's admission, they were required to complete a resident's admission assessment on, or before, the date of admission. LALD/RN-D and CNS-C stated they did not know the statute requirement. On May 28, 2025, at 4:11 p.m., O/ULP-J stated he arranged for R4 and R5 to move into the facility on May 25, 2025. O/ULP-J stated LALD/RN-D was notified of the admission but it was on a weekend and holiday, so it was difficult for their admission to be completed. LALD/RN-D stated they were the only nurse for the facility while CNS-C was on maternity leave and did not have a backup nurse to assist them in CNS-C's absence. During the interview, the surveyor could hear R4 from his room where he was still up in his electric wheelchair. R4 was moaning loudly and making unintelligible sounds. O/ULP-J stated R4 was showing signs and symptoms of pain.	01610			

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01610	Continued From page 88 The licensee's Assessment and Reassessment policy dated June 24, 2024, indicated, "2. The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery." It further indicated, "12. Assessments are available on weekends and holidays." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01610			
01630 SS=I	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a temporary service plan as required at the time of admission for two of two newly admitted residents (R4, R5). This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01630			

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01630	Continued From page 89 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. It did not indicate how to prepare R4's meals or positioning while eating. R4's After Visit Summary (AVS) from a clinic visit dated March 1, 2024, indicated R4's diet instructions were, "easy to chew," and "thin liquids." R4's resident record lacked an assessment, service plan, or any record completed by the licensee. R4's record lacked prescriber orders for medications or treatments. R4 had no medications prescribed by their provider available to them and had not received their medications since their arrival to the facility on May 25, 2025.	01630			

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01630	Continued From page 90 The licensee had no written direction available to the unlicensed personnel regarding R4's care needs or information in the event of an emergency. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed unlicensed personnel (ULP) provide services and cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. R5 R5 was admitted to the licensee on May 25, 2025. R5's Home Health Certification and Plan of Care form signed by R5's provider on May 22, 2025, indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It indicated R5 required 24-hour supervision due to disorganization and wandering. It indicated R5 required assistance with dressing, continence care, grooming, bathing, medication management, verbal and visual cues, exercise, and health related assistance. R5's resident record lacked an assessment, service plan, or any record completed by the licensee. The licensee had no written direction available to the unlicensed personnel regarding	01630			

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01630	Continued From page 91 R5's care needs or information in the event of an emergency. On May 28, 2025, the surveyor observed R5 throughout the day. The surveyor observed R5 wandering the facility, ULP meal preparation, R5 eating, general assistance, and redirection of wandering behaviors. On May 28, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-C stated they had not yet conducted a comprehensive assessment or bed rail assessment for R4 since their admission on May 25, 2025. CNS-C stated they had five days after a resident was admitted to complete admission assessments, obtain signed orders, and "things like that." CNS-C stated neither R4 or R5 had an assessment or service plan completed. CNS-C stated they were currently on maternity leave and May 28 was their first day back; they stated they only returned because of the survey. CNS-C stated licensed assisted living director/registered nurse (LALD/RN)-D was covering for them to complete nursing duties in their absence. The surveyor questioned how their unlicensed personnel (ULP) could effectively and safely provide cares for R4 and R5 if they had not conducted a nursing assessment or used the assessment to develop a service plan for the residents. CNS-C stated they were told the family for R4 had been teaching the ULPs how to care for R4. ULP-G stated R4's Hoyer lift was broken. The surveyor questioned if R4 had been in their bed since R4's arrival on May 25, 2025. CNS-C and ULP-G stated they had been transferring R4 with the use of two people without the Hoyer. CNS-C stated they were still waiting for R4 and R5's county case manager (CM) to approve services. CNS-C stated they did not know what services would be approved by the CM so they	01630			

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01630	Continued From page 92 didn't know what they could put on R4's service plan. CNS-C stated neither R4 or R5 had a completed service plan. On May 28, 2025, at 10:46 a.m., LALD/RN-D stated ULP-G and ULP-H both worked as a personal care assistant (PCA) with R4 and R5 for approximately six months prior to their arrival to the licensee on May 25, 2025. LALD/RN-D stated both ULPs were hired by the licensee when R4 and R5 moved to the facility on May 25, 2025, to help care for them. On May 28, 2025, at 12:31 p.m., LALD/RN-D stated they had not completed R4 or R5's admission assessments. LALD/RN-D stated a family emergency prevented them from getting to the facility to take care of R4 and R5's admissions. LALD/RN-D stated since R4 and R5 were admitted on May 25, 2025, they still had a few days to complete their admission; they stated they normally try to complete the admission process within five days after a resident was admitted. LALD/RN-D stated they did not have a backup nurse while CNS-C was on maternity leave, so they were the only nurse for the licensee. LALD/RN-D then stated R4 had not been out of bed since R4 arrived to the facility on May 25, 2025, due to R4's broken Hoyer lift, which contradicted the earlier statement of CNS-C. The surveyor requested staff demonstrate a two person transfer for R4. The surveyor asked they only perform the transfer if LALD/RN-D deemed it possible to safely transfer R4. On May 28, 2025, at 12:52 p.m., LALD/RN-D stated they had not been to the facility since R4 and R5 were admitted, they stated the family emergency prevented them from getting to the	01630			

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01630	Continued From page 93 facility. LALD/RN-D stated R5 required 24-hour supervision, reminders, and prompting. On May 28, 2025, at 2:06 p.m., the surveyor observed ULP-G and ULP-F conduct a two person transfer for R4 from their bed to their motorized wheelchair. R4 had contractures in his bilateral legs, arms, and hands. The ULPs lifted R4 from each side putting one of their arms under his thighs and the other under his armpits and around R4's back. R4 made moaning and yelling sounds and had distressed facial expressions consistent with signs of pain or discomfort. R4's right foot was entrapped between their hospital bed and bed rail while the ULPs lifted R4 causing R4 to call out in pain. The surveyors intervened to stop the transfer as R4's foot went unnoticed by the ULPs. The ULPs repositioned R4 then successfully transferred R4 into their wheelchair. The ULPs positioned R4 in their wheelchair and attempted to straighten R4's arms and legs causing R4 to moan, yell, and again express facial grimacing consistent with pain. On May 28, 2025, at 2:14 p.m., the surveyor observed ULP-G use a blender to blend R4's lunch which included salmon, vegetables, and a lettuce salad all mixed together. On May 28, 2025, at 2:30 p.m., the surveyor observed ULP-G feed R4 the above-mentioned blended food. On May 28, 2025, at 2:42 p.m., owner/unlicensed personnel (O/ULP)-J stated R4 and R5 were supposed to be admitted to the licensee on May 9, 2025, but the family did not physically bring him to the facility until May 25, 2025. LALD/RN-D stated they were trying their best to complete admission assessments within five days of a	01630			

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NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
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01630	Continued From page 94 resident's admission. The surveyor explained to LALD/RN-D and CNS-C they did not have five days to complete a new resident's admission, they were required to complete a resident's admission assessment on, or before, the date of admission. LALD/RN-D and CNS-C stated they did not know the statute requirement. On May 28, 2025, at 4:11 p.m., O/ULP-J stated he arranged for R4 and R5 to move into the facility on May 25, 2025. O/ULP-J stated LALD/RN-D was notified of the admission but it was on a weekend and holiday, so it was difficult for their admission to be completed. LALD/RN-D stated they were the only nurse for the facility while CNS-C was on maternity leave and did not have a backup nurse to assist them in CNS-C's absence. During the interview, the surveyor could hear R4 from his room where he was still up in his electric wheelchair. R4 was moaning loudly and making unintelligible sounds. O/ULP-J stated R4 was showing signs and symptoms of pain. On May 28, 2025, at approximately 4:15 p.m., ULP-F and ULP-G both stated they assisted R4 with feeding, hydration, brief changes, dressing, and repositioning. ULP-F and ULP-G were unable to provide the surveyor with any specific instructions for R4's care needs such as how often R4 needed to receive a brief change or repositioning. The licensee's Service Plan policy dated June 24, 2024, indicated, "An individualized service plan is implemented for all residents. Rise Home Healthcare will provide all services required by the current service plan." It indicated, "1. Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the	01630			

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01630	Continued From page 95 resident/responsible party and on the assessed needs identified in the comprehensive assessment." Additionally, it indicated, "4. The initial service plan and any revisions are signed by a representative from Rise Home Healthcare and the resident or resident's representative, indicating agreement with the services to be provided." Finally, it indicated, "1. A temporary service plan and agreement with the resident will be developed if services are initiated and the individualized assessment*** has not been completed. The temporary service plan shall not be effective for more than 72 hours." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01630			
{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,	{01640}			

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{01640}	Continued From page 96 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 licensee failed to ensure all services required by the service plan were implemented and provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with the following services: - assistance with dressing; 2 hours per day; - assistance with self-feeding; 1 hour per day; - assistance with grooming; 1 hour per day; - assistance with toileting; 1 hour per day; - assistance with bathing; 30 minutes per day; - medication reminders; 1 hour per day; - treatment and exercises, verbal and visual; 1 hour per day; - medication administration; 1 hour per day;	{01640}			

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{01640}	Continued From page 97 - hands-on assistance with transfers and mobility; 30 minutes per day; - treatments /therapies; 2 hours per day; - eating assistance; 1 hour per day; - housekeeping and linen change; 1hour per day; and - socialization; 5 hours per day. R2's service documentation entitled Charting View 14 Days dated May 15, 2025, through May 28, 2025, indicated the following services: - assistance in making appointments; - room cleaning; - verbally or visually remind to take all prescribed medication; - laundry; - meals/beverages; - transportation medical and non medical; - shopping; - snacks/beverages; - socialization/ recreation; and - therapeutic exercises. R2's service documentation charting did not include the following services required by the service plan: - assistance with dressing; 1 hour per day; - assistance with grooming; 1 hour per day; - assistance with toileting; 1 hour per day; - assistance with bathing; 30 minutes per day; and - hands-on assistance with transfers and mobility; 30 minutes per day. R3 R3 was admitted to the licensee on September 12, 2023, and received assisted living services. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with	{01640}			

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{01640}	Continued From page 98 the following services: - assistance with dressing; 30 minutes per day; - assistance with grooming; 30 minutes per day; - assistance with bathing; 30 minutes per day; - medication reminders, verbal; 1 hour per day; - treatment and exercises, verbal and visual; 1 hour per day; - medication administration; 1 hour per day; - housekeeping and linen change; 5 hour per day; and - socialization; 3 hours per day. R3's service documentation entitled Charting View 14 Days dated May 15, 2025, through May 28, 2025, indicated the following services: - assistance in making appointments; - self medication; - room cleaning; - dressing, grooming, bathing, continence care, positioning, eating, walking, wheeling, transferring, - assistance with ADLs; - verbally or visually remind to take all prescribed medication; - laundry; - meals/beverages; - transportation medical and non-medical; - shopping; - snacks/beverages; - socialization/ recreation; and - therapeutic exercises. R3's service plan did not include the following services which were included in the service documentation charting: - assistance with continence care, positioning, walking, wheeling, transferring, and self-medication.	{01640}			

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{01640}	Continued From page 99 On May 29, 2025, at 1:14 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did go through R2 and R3's chart to fix mismatches between the service plan and the service documentation charting, but the system did not save the changes. LALD/RN-D stated they had a lot of issues with the computer system. The licensee's Service Plan policy dated June 24, 2024, indicated the licensee would implement and provide all services required by the current service plan. No further information was provided.	{01640}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	{01730}			

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{01730}	Continued From page 100 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) reconciled medication orders for two of four residents (R2, R3) and failed to ensure the RN developed a current individualized medication management record or prepared and include in the service plan a written statement of the medication management services that will be provided for two of four residents (R4, R5). 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	{01730}			

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{01730}	Continued From page 101 of the residents). The findings include: MEDICATION RECONCILIATION R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's diagnosis included chronic kidney failure, kidney transplant. R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with dressing, grooming, toileting, bathing, medication reminders, medication administration, and hands-on assistance with transfers, and mobility. R2's MAR for the month of May 2025, indicated R2 was taking the following medications: - amlodipine (Norvasc) 10mg, take one tab daily; - aspirin 81mg tab, take one tab daily; - atorvastatin 20mg tab, take 1 tab daily; - carvedilol (Coreg) 6.25mg tab, take 1 tab twice daily; - CellCept (mycophenolate mofetil) 250mg tab, take 3 tabs every 12 hours; - hydralazine 50mg tab, take 2 tab twice daily; - hydrochlorothiazide 12.5mg cap, take 1 cap daily; - losartan 100mg tab, 1 tab daily; - magnesium 64mg tab, take 2 tabs every morning and 1 tab each evening; - metformin 500mg tab, take 4 tablets with evening meals; - Pepcid (famotidine) 20mg tab, take 1 tab by mouth at bedtime; - potassium chloride 20 milliequivalent (mEq)	{01730}			

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{01730}	Continued From page 102 tab, take 1 tab twice daily; - prednisone 5mg tab, taper as directed 4/15-5/20 (1.5 tab) 7.5mg, 5/20 (1 tab) 5mg; - Prograf 4 mg cap, take 2 cap every morning and take 6 cap every evening; - vitamin D (cholecalciferol) 1000 unit, take 2 tabs (2000mg) daily; - Colace 100mg cap take 1 cap every 12hours PRN (as needed); - Senokot 25mg tab, take 2 tabs at bedtime PRN; and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3. R2's record included the most recent signed physician order on a Department of Health and Human Services for Medicare & Medicaid form entitled Home health Certification and Plan of Care dated September 19, 2023. The form indicated R2 was taking the following medications: - CellCept 250mg cap take three tabs by mouth every 12 hours; - Envarsus XR 4 mg tab, take four tabs by mouth daily; - prednisone 5mg tab PRN; - aspirin 81mg tab take 1 tab by mouth daily; - Bactrim 400-80mg tab take 1 tab by mouth daily; - Valcyte 450mg tablet take 2 tablets by mouth daily; - Pepcid 20mg tab, take 1 tab by mouth at bedtime; - Colace 100mg take 1 cap by mouth every twelve hours; - Senokot 8.5mg tab take 2 tabs by mouth daily; - Coreg 25mg tab take 2 tabs by mouth twice daily; - Norvasc 10mg tab take 1 tab by mouth daily;	{01730}			

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{01730}	Continued From page 103 - hydralazine 50mg tab take two tabs by mouth twice daily; and - K-phos-neutral 250mg tab take 4 tabs by mouth twice daily. R2's MyChart (electronic system offered to patients that provide secure online access to portions of their medical records) document dated February 24, 2025, with a list of medications ready for pick up and list of medication recently sent to R2: List of medications ready for pick up: - potassium chloride 20meq tab, take 2 tabs daily (on MAR, not on signed provider orders). List of medication sent to the licensee's address for R2 on February 24, 2025: - metformin 500mg extended-release tab, take 2 tabs daily with evening meal (on MAR, not on signed provider orders); - cholecalciferol 1000 units tab, take 2 tabs daily (on MAR, not on signed provider orders); - atorvastatin 20mg tab, take 1 tab at bedtime (on MAR, not on signed provider orders); - losartan 100mg tab, take 1 tab daily (on MAR, not on signed provider orders); - mycophenolate mofetil 250mg cap, take 3 caps every 12 hours; - Envarsus extended release 24 tab 4mg tab, take 2 tabs daily (on signed provider orders, not on MAR); - amlodipine 10mg tab, take 1 tab daily; - prednisone 5mg tab, take 1 tab daily (MAR indicated to taper, signed provider orders indicated PRN); - hydralazine 50mg tab, take 2 tabs daily (MAR indicated 25mg 1 tab twice daily, signed provider orders indicated 50mg twice daily); and - carvedilol 6.25mg tabs, take 2 tabs in the	{01730}			

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{01730}	Continued From page 104 morning and 2 tabs in the evening (MAR indicated 6.25mg tab, take 1 tab twice daily, signed provider orders indicated 25mg tab take 2 tabs twice daily). List of medication for refill due soon: - cetirizine 10 mg tab, take 1 tab daily (not on MAR, not on signed provider orders); - mag 64mg tab take 2 tabs by mouth every morning and 1 tab each evening. Separate from transplant medication by 2 hours (on MAR, not on signed provider orders); and - famotidine 20mg, take 1 tab twice daily (MAR and signed provider orders indicated 20mg tab, take 1 tab by mouth at bedtime). Medications listed on R2's MAR but not on R2's physician order or R2's MyChart documents: - hydrochlorothiazide 12.5mg cap, take 1 cap daily; and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3. R2's MAR indicated the following changes were made to the following medications on May 1, 2025: - losartan 50mg take 1 tablet daily was discontinued on May 1, 2025, and losartan 100mg 1 tablet daily was started on May 1, 2025; and - hydralazine 25mg tablet twice daily was discontinued on May 1, 2025, and hydralazine 50mg 2 tablets twice daily was started on May 1, 2025. R3 R3 admitted to the licensee on September 12, 2023, and began receiving assisted living services.	{01730}			

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{01730}	Continued From page 105 R3's diagnosis included depressive disorder and alcohol use. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, housekeeping, linen change, and socialization. R3's MAR for the month of May 2025, indicated R3 was taking the following medications: - hydroxyzine pamoate 25mg cap, take 1 cap 3 times a day PRN; - naltrexone 50mg tab, take 1 tab once a day; - prazosin 1mg tab take 2 tabs at bedtime once daily; - sertraline 50mg tab, take 1 tab once daily; - trazadone 50mg take 1-3 tab at bedtime once daily; and - ibuprofen 400mg tab, take 1 tab PRN for pain. R3's record included the most recent signed physician order on a Department of Health and Human Services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 12, 2023. The form indicated R3 was taking the following medications: - sertraline 50mg tab, one tab daily with food; - naltrexone 50mg tab, one tab daily; - ibuprofen 600mg tab as needed (no other direction) (signed order indicated a dose different than the MAR); - trazadone 50mg one to two tab (no other direction) (signed order indicated a dose different than the MAR); - folic acid 1000 mcg tab one daily (not on MAR); - vitamin B1 100mg tab, 1 daily (not on MAR);	{01730}			

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{01730}	Continued From page 106 and - Tab-A-Vite tab, 1 daily (not on MAR). R3's unsigned after visit summary (AVS) dated January 13, 2025, indicated the following medications were current as of January 13, 2025: - acetaminophen 325mg, take one to two tab every 4 hours PRN for mild pain; - folic acid 1mg, take one tablet daily; - gabapentin 300mg cap, take one cap twice daily; - hydroxyzine pamoate 25mg cap, take 1 cap by mouth up to 3 times daily as PRN; - ibuprofen 400mg tab, take one tab four times daily PRN; - naltrexone 50mg tab, take 1 tab 50 mg daily; - nicotine 7mg/24hr patch, (no further order detail was listed on the AVS); - prazosin 1mg cap, take 2 caps at bedtime; - sertraline 50mg tab, take 1 tab daily; and - trazadone 50mg tab, take 1 tab at bedtime PRN. Medications listed on January 13, 2025, AVS as current but not on R3's MAR: - acetaminophen 325mg, take one to two tab every 4 hours PRN for mild pain (not on MAR, not on signed provider orders); - gabapentin 300mg cap, take one cap twice daily (not on MAR, not on signed provider orders); - hydroxyzine pamoate 25mg cap, take 1 cap by mouth up to 3 times daily as PRN (on MAR, not on signed provider orders); and - nicotine 7mg/24hr patch (not on MAR, not on signed provider orders); On May 29, 2025, at 12:01 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did not get the chance to correct the orders for the above-mentioned	{01730}			

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{01730}	Continued From page 107 residents yet. LALD/RN-D stated they did not have current orders for R2 or R3, and the unlicensed personnel (ULP) were supposed to follow the labels on the medication bottles for medication orders and frequencies. NO MEDICATION MANGMENT PLAN R4 R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed ULP provide services and cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. R4's record lacked prescriber orders for medications or treatments. R4 had no	{01730}			

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{01730}	Continued From page 108 medications prescribed by their provider available to them and had not received their medications since their arrival to the facility on May 25, 2025. The licensee had no written direction available to the unlicensed personnel regarding R4's care needs or information in the event of an emergency. On May 27, 2025, at 11:26 a.m., via telephone, LALD/RN-D stated they were not aware of R4's status or medication needs. LALD/RN-D stated they did not think R4 had any medication at the facility. On May 28, 2025, at 9:38 a.m., LALD/RN-D stated R4 had no medications and R5 (mentioned below) had two medications. On May 28, 2025, at 12:03 p.m., via telephone, R4's case manager (CM)-L stated R4 was supposed to be receiving the following medications: - Sylivadin cream; - Senna; - Ensure; - Mineral oil; - Baclofen 10mg three times a day; and - Tylenol as needed. R4's resident record lacked an assessment, service plan, or any record completed by the licensee including a medication management plan with the following required content: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	{01730}			

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{01730}	Continued From page 109 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. R5 R5 was admitted to the licensee on May 25, 2025. R5's Home Health Certification and Plan of Care form signed by R5's provider on May 22, 2025, indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It indicated R5 required 24-hour supervision due to disorganization and wandering. It indicated R5 required assistance with dressing, continence care, grooming, bathing, medication management, verbal and visual cues, exercise, and health related assistance. The document indicated R5 took the following medications:	{01730}			

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{01730}	Continued From page 110 - acetaminophen 500mg, one tablet every six hours PRN; - quetiapine 200mg, one tablet at bedtime; and - quetiapine 25mg, one tablet up to three times daily PRN for agitation. On May 28, 2025, the surveyor observed R5 throughout the day. The surveyor observed R5 wandering the facility, ULP meal preparation, R5 eating, general assistance, and redirection of wandering behaviors. R5's resident record lacked an assessment, service plan, or any record completed by the licensee including a medication management plan with the following required contents: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	{01730}			

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{01730}	Continued From page 111 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. On May 27, 2025, at 12:50 p.m., via telephone, LALD/RN-D stated they did not do any paperwork (including an assisted living contract, admission assessment, individual abuse prevention plan, medication management plan, treatment and therapy management plan and service plan) for R4 or R5's admission since there was no nurse or LALD at the facility when the resident's moved in. On May 28, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated they had not been to the facility for the last three months as they were on maternity leave. CNS-C stated they were not aware of R4 and R5's admission. CNS-C stated, "I have not been here for the last three months you guys [referring to the surveyors] came here yesterday and I was asked to come in today and I came in to learn more about them [referring to R4 and R5] today." On May 28, 2025, at 9:54 a.m., LALD/RN-D stated they did not have any medication for R5. LALD/RN-D stated during the survey was the first time there was a nurse at the facility since R4 and R5's admission, therefore there was no one to put medication or treatment orders into the system and neither resident had received any medication since their admission to the licensee. LALD/RN-D stated the nurse had to come in and go through the medications and the orders before putting the medications into the system. LALD/RN-D stated they were supposed to request treatment and medication orders from R4's doctor but they did	{01730}			

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{01730}	Continued From page 112 not get that far. LALD/RN-D further stated that they were hoping for delaying admissions of R4 and R5, but the owner did not take their recommendation and said it was ok to take the residents. On May 28, 2025, at 4:11 p.m., owner/unlicensed personnel (O/ULP)-J stated he arranged for R4 and R5 to move into the facility on May 25, 2025. O/ULP-J stated LALD/RN-D was notified of the admission but it was on a weekend and holiday, so it was difficult for their admission to be completed. LALD/RN-D stated they were the only nurse for the facility while CNS-C was on maternity leave and did not have a backup nurse to assist them in CNS-C's absence. The licensee's Medication Administration policy dated June 24, 2024, indicated a licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber. No further information was provided.	{01730}			
{01750} SS=H	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel	{01750}			

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{01750}	Continued From page 113 about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and evaluated the ULPs' ability to competently perform the task for two of three employees (unlicensed personnel (ULP)-H, ULP-G). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-H was hired on May 25, 2025, to provide direct care services to residents. ULP-G was hired on May 25, 2025, to provide direct care services to residents. The licensee's employee schedule for the month of May 2025, did not include ULP-H or ULP-G. On May 27, 2025, at 9:35 a.m., upon arrival to the facility, the surveyor observed ULP-H open the door for the surveyor. ULP-H introduced themselves and stated they were a new	{01750}			

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{01750}	Continued From page 114 employee. ULP-H stated they worked night shifts for the licensee and stated the licensee had four residents in the building. On May 27, 2025, at 9:58 a.m., the surveyor observed ULP-H retrieve a preset pill box from the locked medication cabinet and bring it to R3's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into R3's hand and R3 took the pills. ULP-H stated to the surveyor they did not have password to the computer so they would just tell the morning staff that R3 took their medications. ULP-H stated they did not know much about medications, and they did not do charting. ULP-H stated they were trained on how to change another resident, R4, by the licensee's other staff and they helped R4 to a chair with the morning shift ULP. ULP-H stated they worked at another homecare before, and they knew the job. ULP-H was working independently with no other ULP in the facility during this observation. On May 27, 2025, at approximately 10:00 a.m., ULP-A arrived at the licensee and stated they were a day shift personnel. On May 27, 2025, at 10:30 a.m., ULP-G came into the facility and ULP-A introduced ULP-G to the surveyor and stated ULP-G was a new employee and was still in training. On May 27, 2025, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated ULP-H and ULP-G had not been trained officially, and there were no training documents or any demonstration of competency for either ULP. LALD/RN stated the clinical nurse supervisor (CNS) was on maternity leave since April 12, 2025, and LALD/RN-D had a sick child,	{01750}			

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{01750}	Continued From page 115 so they were unable to provide any new hire training for the ULPs. LALD/RN-D stated ULP-H was not supposed to give medication to a resident as he did not have a background study completed, and ULP-G was supposed to be with ULP-H. LALD/RN-D stated ULP-G was allowed to pass medications to residents. LALD/RN-D also stated ULP-G had worked with R4 before and they started working for the licensee when R4 moved to the licensee. On May 27, 2025, at 1:03 p.m., R3 stated ULP-H had been working at the licensee for about a week or two. R3 stated they had been given medications by both ULP-G and ULP-H. On May 27, 2025, at 1:37 p.m., ULP-G stated they give food to residents, they change and clean R4, but they do not give medications. On May 27, 2025, at 1:44 p.m., LALD/RN-D stated ULP-G and ULP-H were not included in the May work schedule as they (LALD/RN-D) did not get the chance to update the schedule and stated they would add the two new employees to the June work schedule. The licensee's Staff Competency policy dated Jun 24, 2024, indicated all residents will receive quality services by staff who are trained, educated and competent in the delivery of assisted living services. Unlicensed personnel may not work for the licensee until they have successfully passed the written exam and demonstrated competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	{01750}			

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{01760}	Continued From page 116	{01760}			
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders were accurately transcribed to the medication administration record and failed to accurately document medication administration for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	{01760}			

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{01760}	Continued From page 117 R1 R1 was admitted to the licensee on October 15, 2020, and received assisted living services. R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with dressing, haircare, grooming, toileting, bathing, medication reminders, treatment and exercises reminders, medication administration, hands-on assistance with transfers and mobility, personal laundry, housekeeping and linen change, and I am ok check service. The licensee's Discharge or Deceased Resident Roster dated July 5, 2022 [sic] indicated R1 was admitted to the licensee on August 20, 2023, and discharged on May 24, 2025. R1's medication administration record (MAR) for the months of March, April, and May 2025 indicated R1 was taking the following medications: - alfuzosin 10 mg tab, take 1 tab once daily; - aspirin 81mg tab, 1 tab daily; - calcium carbonate 400-500mg tab, take 1 tab daily; - Certavite 1tab daily; - clobesatol propionate 0.05%, apply topically once daily; - esomeprazole magnesium 1 cap 20mg, take 1 cap daily; - gabapentin 100mg cap, take 1 cap at bedtime; - stiolo respimat 2.5 micrograms (mcg) inhaler, inhale 2 puffs daily; - triamcinolone 0.5% cream 15gram apply topically to affected area three times daily; - acetaminophen 1tab 500mg take 1 tab every 4 hours for pain or fever as needed; - albuterol sulfate take 2 puffs twice a day as	{01760}			

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{01760}	Continued From page 118 needed; and - carboxymethylcellulose sodium 0.5%, instill 1 drop into eye as needed twice daily as needed. R1's MAR dated March 1, through May 31, 2025, lacked documentation on all medication administration for all shifts as follows: March 5, through March 31, 2025; April 1, through April 30, 2025; May 1, through May 7, 2025; and May 9, through May 21, 2025. The MAR indicated alfuzosin 10mg, creative 1 tab, clobesatol propionate 0.05%, and esomeprazole magnesium 1 cap 20mg, was administered to R1 on May 8, and May 27, 2025, but lacked documentation on the rest of R1's medication on May 8, and 27, 2025. On May 28, 2025, at 10:30 a.m., licensed assisted living director/ registered nurse (LALD/RN)-D stated R1 was discharged from the facility on May 24, 2025, and confirmed R1 was receiving services at the facility prior to their discharge. On May 28, 2025, at 10:34 a.m., LALD/RN-D stated they did not know why R1's MAR for the above listed dates lacked medication administration documentation. LALD/RN-D stated R1 had been getting their medications and stated their whole charting system was not working. The surveyor referred LALD/RN-D to R3's medication documentation charting and inquired why the system was working for R3 but not working for R1. LALD/RN-D stated, "I do not know, that is weird." R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services.	{01760}			

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{01760}	Continued From page 119 R2's diagnosis included chronic kidney failure, kidney transplant. R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with dressing, grooming, toileting, bathing, medication reminders, medication administration, and hands-on assistance with transfers and mobility. R2's record included a signed physician order on a Department of Health and Human Services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 19, 2023. The form indicated R2 was taking the following medications: - CellCept 250mg cap take 3 tab by mouth every 12 hours; - Envarsus XR 4 mg tab, take 4 tabs by mouth daily; - prednisone 5mg tab as needed; - aspirin 81mg tab take 1 tab by mouth daily; - Bactrim 400-80mg tab take 1 tab by mouth daily; - Valcyte 450mg tablet take 2 tabs by mouth daily; - Pepcid 20mg tab, take 1 tab by mouth at bedtime; - Colace 100mg take 1 cap by mouth every twelve hours; - Senokot 8.5mg tab take 2 tabs by mouth daily; - Coreg 25mg tab take 2 tabs by mouth twice daily; - Norvasc 10mg tab take 1 tab by mouth daily; - hydralazine 50mg tab take 2 tabs by mouth twice daily; and - K-phos-neutral 250mg tab take 4 tabs by mouth twice daily. R2's MAR for the month of May 2025 indicated	{01760}			

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NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
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{01760}	Continued From page 120 R2 was taking the following medications: - amlodipine 10mg tab, take 1 tab daily; - aspirin 81 mg tab, take 1 tab daily; - atorvastatin 20mg tab, take 1 tab daily; - carvedilol 6.25mg tab, take 1 tab twice daily; - CellCept 250mg cap, take 3 caps every 12 hours; - hydralazine 25mg tab, take 1 tab twice daily; - hydrochlorothiazide 12.5mg cap, 1 cap daily; - losartan 50mg, take 1 tab daily; - magnesium 64mg tab, take 2 tabs every morning and 1 tab each evening; - metformin 500mg take 4 tabs with evening meal; - Pepcid 20mg tab, take 1 tab at bedtime; - potassium chloride 20mEq tab take 1 tab twice daily; - prednisone 5mg tab, taper as directed 4/15-5/20 (1.5 tab) 7.5mg, 5/20 (1 tab) 5mg; - Prograf 4 mg cap, take 2 caps every morning and take 6 caps every evening; - Vitamin D 1000 unit, take 2 tabs (2000mg) daily; - Colace 100mg cap take 1 cap every 12hours PRN; - Senokot 25mg tab, take 2 tabs at bedtime PRN; and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3. R2's MAR dated March 1, through March 31, 2025, and May 1 through May 31, 2025, was not transcribed according to the signed provider's orders. R2's flight booking record issued on January 15, 2025, indicated R2 was booked to travel out of the country on March 25, 2025, and return on June 24, 2025. A separate flight booking record under the same airline record locator code as the	{01760}			

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{01760}	Continued From page 121 above-mentioned document reissued on April 19, 2025, indicated a return date of May 21, 2025. R2's MAR for the month of March 2025, indicated no medication administration charting from March 5 to March 31, 2025. According to the airline booking mentioned above R2 had not left the country until March 25, 2025. R2's record lacked documentation on all medication administration for all shifts from March 5 through March 25, 2025. R2's MAR for the month of May 2025, indicated R2 had received all medications for all shifts from May 16, 2025, through May 27, 2025. According to the flight booking record mentioned above R2 was still out of the country from May 16, 2025, through May 21, 2025. On May 28, 2025, at approximately 2:15 p.m., LALD/RN-D stated they did not know why the medication documentation was charted as though R2 had received medication from May 16, 2025, through May 21, 2025, while out the country. R3 R3 admitted to the licensee on September 12, 2023, and began receiving assisted living services. R3's diagnosis included depressive disorder and alcohol use. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, housekeeping, linen change, and socialization. R3's record included a signed physician order on	{01760}			

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{01760}	Continued From page 122 a Department of Health and Human Services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 12, 2023. The form indicated R3 was taking the following medications: - sertraline 50mg tab, 1 tab daily with food; - naltrexone 50mg tab, 1 tab daily; - ibuprofen 600mg tab as needed (no other direction); - trazadone 50mg 1 to 2 tabs, (no other direction); - folic acid 1000 mcg tab 1 daily; - Vitamin B1 100mg tab, 1 daily; and - Tab-A-Vite tab, 1 daily. R3's MAR for the month of May 2025, indicated R3 was taking the following medications: - hydroxyzine pamoate 25mg cap, take 1 cap 3 times a day as needed; - naltrexone 50mg tab, take 1 tab once a day; - prazosin 1mg tab take 2 tabs at bedtime once daily; - sertraline 50mg tab, take 1 tab once daily; - trazadone 50mg take 1-3 tab at bedtime once daily; and - ibuprofen 400mg tab, take 1 tab PRN for pain. R3's MAR dated May 1, through May 26, 2025, was not transcribed according to the signed provider's orders. On May 27, 2025, at 9:58 a.m., the surveyor observed ULP-H retrieve a preset pill box from the locked medication cabinet and bring it to R3's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into R3's hand and R3 took the pills.	{01760}			

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{01760}	Continued From page 123 On May 29, 2025, at 1:20 p.m., licensed assisted living director/ registered nurse (LALD/RN)-D stated R2 left for another country soon after the last state survey. LALD/RN-D stated they produced a new Department of Health and human services center for Medicare and Medicaid form for R2 and R3 and added the medications which were not included in the form to medication lists on the new form and ULP-E faxed the form to the providers for signature. LALD/RN-D stated they did not get the forms back from the providers. The surveyor asked what they meant when they said they added the missing medication to the list and inquired if LALD/RN-D had verified that there was an actual physician order for the medications not included on the previous form before adding the medications to the list. LALD/RN-D stated they did not have any prescriptions or signed orders, they added those medications to the list of R2 and R3's medication profile based on the labels of the pill bottles that they received from the pharmacy. LALD/RN-D was unable to provide a copy of the form they mentioned above. The licensee's Medication Documentation policy dated June 24, 2024, indicated each medication administered by the licensee staff will be documented in the resident's clinical record. Documentation will be complete, accurate, and legible. The licensee's Medication Orders policy dated June 24, 2024, read, "Policy Statement: Rise Home Healthcare will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted living Bill of Rights and in the Health Insurance Portability and Accountability Act. Procedure:	{01760}			

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{01760}	Continued From page 124 1. Rise Home Healthcare will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. 2. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. 3. Verbal prescription orders from an authorized prescriber will be received by a nurse or pharmacist. a. The pharmacist, LPN or RN acting on behalf of the prescriber may communicate to the pharmacy provider a prescription drug order by a practitioner authorized to prescribe drugs or devices. b. The prescription drug orders will be transmitted via facsimile or a secure electronic format to the pharmacy c. Schedule II controlled substances require an original written prescription drug order manually signed by the authorized practitioner except in an emergency i. Immediate administration of the controlled substance is necessary for the proper treatment of the intended user ii. No appropriate alternative treatment is available iii. It is not reasonably possible for the prescribing practitioner to provide a written prescription drug order to the pharmacy. 4. When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. 5. All prescriptions and orders received by Rise Home Healthcare either verbally, in writing or electronically will be kept confidential. 6. When staff become aware of any medications or dietary supplements being used by a resident that are not included in the assessment, the	{01760}			

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{01760}	Continued From page 125 information will be documented, and the RN will be notified. 7. Rise Home Healthcare has determined not to require a prescription for over-the- counter medications and dietary supplements. These medications will be included on the Medication Profile annually renewed by the physician." No further information was provided.	{01760}			
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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented medication setup for two of two residents with set up medications (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 126 R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's diagnosis included chronic kidney failure, kidney transplant. R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with dressing, grooming, toileting, bathing, medication reminders, medication administration, and hands-on assistance with transfers, and mobility. R2's record included a signed physician order on a Department of Health and Human Services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 19, 2023. The form indicated R2 was taking the following medications: - CellCept 250mg cap take 3 tab by mouth every 12 hours; - Envarsus XR 4 mg tab, take 4 tabs by mouth daily; - prednisone 5mg tab as needed; - aspirin 81mg tab take 1 tab by mouth daily; - Bactrim 400-80mg tab take 1 tab by mouth daily; - Valcyte 450mg tablet take 2 tabs by mouth daily; - Pepcid 20mg tab, take 1 tab by mouth at bedtime; - Colace 100mg take 1 cap by mouth every twelve hours; - Senokot 8.5mg tab take 2 tabs by mouth daily; - Coreg 25mg tab take 2 tabs by mouth twice daily; - Norvasc 10mg tab take 1 tab by mouth daily; - hydralazine 50mg tab take 2 tabs by mouth twice daily; and	01770			

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01770	Continued From page 127 - K-phos-neutral 250mg tab take 4 tabs by mouth twice daily. R2's MAR for the month of May 2025 indicated R2 was taking the following medications: - amlodipine 10mg tab, take 1 tab daily; - aspirin 81 mg tab, take 1 tab daily; - atorvastatin 20mg tab, take 1 tab daily; - carvedilol 6.25mg tab, take 1 tab twice daily; - CellCept 250mg cap, take 3 caps every 12 hours; - hydralazine 25mg tab, take 1 tab twice daily; - hydrochlorothiazide 12.5mg cap, 1 cap daily; - losartan 50mg, take 1 tab daily; - magnesium 64mg tab, take 2 tabs every morning and 1 tab each evening; - metformin 500mg take 4 tabs with evening meal; - Pepcid 20mg tab, take 1 tab at bedtime; - potassium chloride 20mEq tab take 1 tab twice daily; - prednisone 5mg tab, taper as directed 4/15-5/20 (1.5 tab) 7.5mg, 5/20 (1 tab) 5mg; - Prograf 4 mg cap, take 2 caps every morning and take 6 caps every evening; - Vitamin D 1000 unit, take 2 tabs (2000mg) daily; - Colace 100mg cap take 1 cap every 12hours PRN; - Senokot 25mg tab, take 2 tabs at bedtime PRN; and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3. R2's MAR for the month of May 2025, indicated R2 had received all of their medications for all shifts from May 16, 2025, through May 27, 2025, administered by the licensee's staff. R3	01770			

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01770	Continued From page 128 R3 admitted to the licensee on September 12, 2023, and began receiving assisted living services. R3's diagnosis included depressive disorder and alcohol use. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, housekeeping, linen change, and socialization. R3's record included a signed physician order on a Department of Health and Human Services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 12, 2023. The form indicated R3 was taking the following medications: - sertraline 50mg tab, 1 tab daily with food; - naltrexone 50mg tab, 1 tab daily; - ibuprofen 600mg tab as needed (no other direction); - trazadone 50mg 1 to 2 tabs, (no other direction); - folic acid 1000 mcg tab 1 daily; - Vitamin B1 100mg tab, 1 daily; and - Tab-A-Vite tab, 1 daily. R3's MAR for the month of May 2025, indicated R3 was taking the following medications: - hydroxyzine pamoate 25mg cap, take 1 cap 3 times a day as needed; - naltrexone 50mg tab, take 1 tab once a day; - prazosin 1mg tab take 2 tabs at bedtime once daily; - sertraline 50mg tab, take 1 tab once daily; - trazadone 50mg take 1-3 tab at bedtime once daily; and - ibuprofen 400mg tab, take 1 tab PRN for	01770			

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01770	Continued From page 129 pain. On May 27, 2025, at 9:58 a.m., the surveyor observed unlicensed personnel (ULP)-H retrieve a preset pill box from the locked medication cabinet and bring it to R3's room located on the lower level. ULP-H opened the Tuesday morning slot and dumped three unknown pills into R3's hand and R3 took the pills. On May 27, 2025, at 10:45 a.m., the surveyor asked to see the medication cabinet. ULP-A opened the medication cabinet and there was only one preset pill box with R2's name handwritten on the side of the pill box. ULP-A stated the pill box was not R2's and stated the pill box belonged to R3. The surveyor asked about R2's medications. ULP-A stated R2 was out of the country. The surveyor asked to see R2's room. ULP-A and the surveyor went downstairs to R2's room to find R2 sitting on their bed. ULP-A stated R2 just returned during the survey (May 27, 2025). On May 27, 2025, at 10:50 a.m., R2 stated their medications were in their car. On May 27, 2025, at 10:54 a.m., the surveyor observed R2 walk back into the licensee's facility carrying white pill boxes with a light blue top. On May 27, 2025, at 11:02 a.m., R2 stated they had a doctor's appointment that morning and that was why the pill box was in their car. The surveyor asked if they had an after-visit summary from the visit. R2 then stated they went to the county office to renew their insurance not to the doctor's office. On May 27, 2025, at 11:06 a.m., licensed	01770			

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01770	Continued From page 130 assisted living director/registered nurse (LALD/RN)-D stated R2 came back from out of the country few days ago. LALD/RN-D stated ULP-A might have thought that R2 was at adult day care when they said R2 was not at the facility. LALD/RN-D stated they did handle R2's medication administration but R2 had been gone out of the country. LALD/RN-D stated they were not able to come into the facility to go through R2's medication after R2 returned. LALD/RN-D stated, "Since he has been back, I was not able to come in to go through his medication, I was going to come in today or tomorrow to set it up." LALD/RN-D further stated the pill box that R2 brought from their car was set up before R2 left. The surveyor inquired why R2 carried their pillbox with them in their car. LALD/RN-D stated, "I do not know how to answer that, I have no idea. He should not have access to it. So, I do not know. Maybe he had an appointment today and they gave it to him. He is not independent with meds here but if he requests to take it himself, we cannot say no." On May 29, 2025, at 9:35 a.m., LALD/RN-D provided contradictory information and stated they did not do medication set up for any residents, "since we are not here, we let them take it out of the bottle." LALD/RN-D further stated if they had done medication setup, they did not have any documentation for it. On May 29, 2025, at 9:40 a.m., ULP-E stated the dialysis clinic sets up the medications for R2 in a pill box. ULP-E stated R2 takes all of their medications to the clinic, and they set it up for him and he brings it back to the facility. ULP-E was not sure who did the pill set up at the clinic. On May 29, 2025, at 9:44 a.m., LALD/RN-D	01770			

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01770	Continued From page 131 stated the licensee's ULPs administered R2's medication from the preset pill box set up by the dialysis clinic. The surveyor inquired how the nurse and the ULPs at the licensee's facility would know what was put in the pill box, and how they would document for medication administration. LALD/RN-D stated the clinic did send a note and provided the surveyor with a handwritten document from R2's clinic dated September and October 2022. LALD/RN-D insisted the document was from 2025. A calendar printed from calendarDate.com dated September 1, through September 30, and October 1 through 24, 2022, with R2's name label on top left corner of the document indicated the following: - Valcyte 2 pills twice daily from September 1, through September 22, 2022; - Valcyte 2 pills once daily from September 23, through October 23, 2022; and - stop Valcyte on September 24, 2022. The document did not mention about medication set ups for R2 and the document did not include information about any of R2's medications other than the Valcyte. On May 29, 2025, at 10:54 a.m., LALD/RN-D stated they had not set up medication in a pill box for anybody in over two months. On May 29, 2025, at 10:58 a.m., the surveyor asked LALD/RN-D to open the licensee's medication cabinet. LALD/RN-D opened the medication cabinet and there was a pill box with R3's name on the side of the box. The surveyor inquired who did the medication set up. LALD/RN-D stated, "oh! I am not sure, I set this up? I do not know; I think I set this up. I do not know why I set it up." LALD/RN-D stated they did	01770			

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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	
01770	Continued From page 132 not have documentation for setting up the medications. On June 6, 2025, at 1:21 p.m., via telephone R2's nurse from the dialysis clinic stated they had not set up R2's pills since March of 2022. Due to conflicting information received from the licensee's employees, the surveyor was unable to discern who did the medication set up for R2. R2 and R3's record lacked 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 which was supposed to be done at the time of setup and by the nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two newly admitted residents (R4, R5).	01820			

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01820	Continued From page 133 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound and wheelchair bound. R4's resident record lacked an assessment, service plan, and medication orders. R4 did not have medications available to them and had not received their medications since their arrival to the facility on May 25, 2025. R4's After Visit Summary (AVS) dated March 1, 2024, indicated R4 took nitrofurantoin for five days starting March 1, 2024; there were no other medications identified on the AVS. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed unlicensed personnel (ULP) provide services and cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4	01820			

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01820	Continued From page 134 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. On May 27, 2025, at 11:26 a.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated they were not aware of what medications R4 was prescribed. LALD/RN-D stated they did not think R4 had any medication at the facility. R5 R5 was admitted to the licensee on May 25, 2025. R5's Home Health Certification and Plan of Care form signed by R5's provider on May 22, 2025, indicated R5 had a diagnosis of schizoaffective disorder, bipolar, tardive dyskinesia and post-traumatic stress disorder (PTSD). It indicated R5 required 24-hour supervision due to disorganization and wandering. It indicated R5 required assistance with dressing, continence care, grooming, bathing, medication management, verbal and visual cues, exercise and health related assistance. It indicated R5 took the following medications: - acetaminophen 500mg, one tablet every six hours as needed (PRN); - quetiapine 200mg, one tablet at bedtime; and - quetiapine 25mg, one tablet up to three times daily PRN for agitation. R5's resident record lacked an assessment and service plan. R5 did not have medications available to them and had not received their medications since their arrival to the facility on May 25, 2025.	01820			

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01820	Continued From page 135 On May 28, 2025, the surveyor observed R5 throughout the day. The surveyor observed R5 wandering the facility, ULP meal preparation, R5 eating, general assistance, and redirection of wandering behaviors. On May 28, 2025, at 9:38 a.m., LALD/RN-D stated R5 had two medications and R4 had no medication. On May 28, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-C stated they had not yet conducted a comprehensive assessment for R4 or R5 since their admission on May 25, 2025. CNS-C stated they had five days after a resident was admitted to complete admission assessments, obtain signed orders, and "things like that." CNS-C stated they were currently on maternity leave and May 28, 2025, was their first day back; they stated they only returned because of the survey. CNS-C stated LALD/RN-D was covering for them to complete nursing duties in their absence. On May 28, 2025, at 12:03 p.m., via telephone, R4's case manager (CM)-I stated the licensee was supposed to be managing R4's medication. CM-I stated R4 was supposed to be on the following medications: - Sylivadin cream; - Senna; - Ensure; - Mineral oil; - Baclofen 10mg three times a day; and - Tylenol as needed. On May 28, 2025, at 12:31 p.m., LALD/RN-D stated they had not had time to get to the facility to take care of medication orders for R4 and R5.	01820			

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01820	Continued From page 136 LALD/RN-D stated they tried to obtain orders for residents within five days after they were admitted. LALD/RN-D stated they did not have a backup nurse while CNS-C was on maternity leave. On May 28, 2025, at 12:52 p.m., LALD/RN-D stated R4 and R5 had not had any medications administered by the licensee since they were admitted to the facility; they were unsure what medications R4 and R5 was supposed to take but knew R4 was supposed to take baclofen. LALD/RN-D stated there were no barriers to requesting medication orders from the prescribers, "just hadn't had a chance to do it." LALD/RN-D stated they had a sick child which had kept them busy. LALD/RN-D stated they had not made any attempt to get R4 or R5's medications. The surveyor explained CM-I told the surveyor R4 was on multiple medications which included baclofen, senna, and Tylenol. LALD/RN-D stated they planned to obtain orders for R4 and R5 today (May 28, 2025). LALD/RN-D stated they talked to R4's family and did not think R4 was on any medication. The surveyor expressed concern to LALD/RN-D about their lack of follow up on R4 and R5's medication orders; R4 may have been without pain management medication for three days. LALD/RN-D then referenced R4's AVS dated March 1, 2024, and stated R4 was only on an antibiotic. The surveyor explained the AVS was over 14 months old and the antibiotic was only to be taken for five days. LALD/RN-D stated they needed to follow up to find out if R4 and R5 had medications they were supposed to be taking. On May 28, 2025, at 1:31 p.m., CNS-C stated they had not administered any medications for R5 since they were admitted. CNS-C stated they had	01820			

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01820	Continued From page 137 medication orders and were working on coordinating with the pharmacy. LALD/RN-D stated they had not had time to take care of R5's medications since their child was sick and CNS-C was on maternity leave. On May 28, 2025, at 2:06 p.m., the surveyor observed ULP-G and ULP-F conduct a two person transfer for R4 from their bed to their motorized wheelchair. R4 had contractures in his bilateral legs, arms, and hands. The ULPs lifted R4 from each side putting one of their arms under his thighs and the other under his armpits and around R4's back. R4 made moaning and yelling sounds and had distressed facial expressions consistent with signs of pain or discomfort. On May 28, 2025, at 2:42 p.m., LALD/RN-D and CNS-C stated they did not know they were required to have medications and services organized on, or before, the date of admission; they believed they had five days to complete the admission process after a resident's arrival. CNS-C stated they did not know the statute requirements. On May 28, 2025, at 4:11 p.m., owner/unlicensed personnel (O/ULP)-J stated he arranged for R4 and R5 to move into the facility on May 25, 2025. O/ULP-J stated LALD/RN-D was notified of the admission but it was on a weekend and holiday, so it was difficult for their admission to be completed. LALD/RN-D stated they were the only nurse for the facility while CNS-C was on maternity leave and did not have a backup nurse to assist them in CNS-C's absence. On May 28, 2025, at 4:11 p.m., CNS-C stated they put in an urgent request to R4's provider for medication orders.	01820			

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01820	Continued From page 138 The licensee's Medication Administration policy dated June 24, 2024, indicated a licensed nurse was responsible for assessing medications to assure that all medications were current and ordered by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01830			

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01830	Continued From page 139 R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's diagnosis included chronic kidney failure, kidney transplant. R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with dressing, grooming, toileting, bathing, medication reminders, medication administration, and hands-on assistance with transfers, and mobility. R2's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 19, 2023. The form indicated R2 was taking the following medications: - CellCept 250mg cap take 3 tab by mouth every 12 hours; - Envarsus XR 4 mg tab, take 4 tabs by mouth daily; - prednisone 5mg tab as needed; - aspirin 81mg tab take 1 tab by mouth daily; - Bactrim 400-80mg tab take 1 tab by mouth daily; - Valcyte 450mg tablet take 2 tabs by mouth daily; - Pepcid 20mg tab, take 1 tab by mouth at bedtime; - Colace 100mg take 1 cap by mouth every twelve hours; - Senokot 8.5mg tab take 2 tabs by mouth daily; - Coreg 25mg tab take 2 tabs by mouth twice daily; - Norvasc 10mg tab take 1 tab by mouth daily; - hydralazine 50mg tab take 2 tabs by mouth twice daily; and	01830			

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01830	Continued From page 140 - K-phos-neutral 250mg tab take 4 tabs by mouth twice daily. R2's MAR for the month of May 2025 indicated R2 was taking the following medications: - amlodipine 10mg tab, take 1 tab daily; - aspirin 81 mg tab, take 1 tab daily; - atorvastatin 20mg tab, take 1 tab daily; - carvedilol 6.25mg tab, take 1 tab twice daily; - CellCept 250mg cap, take 3 caps every 12 hours; - hydralazine 25mg tab, take 1 tab twice daily; - hydrochlorothiazide 12.5mg cap, 1 cap daily; - losartan 50mg, take 1 tab daily; - magnesium 64mg tab, take 2 tabs every morning and 1 tab each evening; - metformin 500mg take 4 tabs with evening meal; - Pepcid 20mg tab, take 1 tab at bedtime; - potassium chloride 20mEq tab take 1 tab twice daily; - prednisone 5mg tab, taper as directed 4/15-5/20 (1.5 tab) 7.5mg, 5/20 (1 tab) 5mg; - Prograf 4 mg cap, take 2 caps every morning and take 6 caps every evening; - Vitamin D 1000 unit, take 2 tabs (2000mg) daily; - Colace 100mg cap take 1 cap every 12hours PRN; - Senokot 25mg tab, take 2 tabs at bedtime PRN; and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3. R3 R3 admitted to the licensee on September 12, 2023, and began receiving assisted living services. R3's diagnosis included depressive disorder and	01830			

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01830	Continued From page 141 alcohol use. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, housekeeping, linen change, and socialization. R3's record included a signed physician order on a Department of Health and Human Services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 12, 2023. The form indicated R3 was taking the following medications: - sertraline 50mg tab, 1 tab daily with food; - naltrexone 50mg tab, 1 tab daily; - ibuprofen 600mg tab as needed (no other direction); - trazadone 50mg 1 to 2 tabs, (no other direction); - folic acid 1000 mcg tab 1 daily; - Vitamin B1 100mg tab, 1 daily; and - Tab-A-Vite tab, 1 daily. R3's MAR for the month of May 2025, indicated R3 was taking the following medications: - hydroxyzine pamoate 25mg cap, take 1 cap 3 times a day as needed; - naltrexone 50mg tab, take 1 tab once a day; - prazosin 1mg tab take 2 tabs at bedtime once daily; - sertraline 50mg tab, take 1 tab once daily; - trazadone 50mg take 1-3 tab at bedtime once daily; and - ibuprofen 400mg tab, take 1 tab PRN for pain. R2 and R3's record included signed physician orders from 2023 that did not match the resident's current medication administration	01830			

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01830	Continued From page 142 records. The record for both residents lacked renewed prescriptions which were due to be renewed in September 2024. On May 29, 2025, at 1:20 p.m., licensed assisted living director/ registered nurse (LALD/RN)-D stated they produced a new Department of Health and Human Services for Medicare and Medicaid form for R2 and R3 and added the medications which were not included in the form to medication lists on the new form and unlicensed personnel (ULP)-E faxed the form to the providers for signature. LALD/RN-D stated they did not get the forms back from the providers. LALD/RN-D was unable to provide the copy of the form that they said was faxed to the providers. LALD/RN-D stated they did not have renewed physician orders for either resident. The licensee's Medication Orders policy dated June 24, 2024, read, "Policy Statement: Rise Home Healthcare will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted living Bill of Rights and in the Health Insurance Portability and Accountability Act. Procedure: 1. Rise Home Healthcare will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. 2. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. 3. Verbal prescription orders from an authorized prescriber will be received by a nurse or pharmacist. a. The pharmacist, LPN or RN acting on behalf of the prescriber may communicate to the pharmacy provider a prescription drug order by a	01830			

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01830	Continued From page 143 practitioner authorized to prescribe drugs or devices. b. The prescription drug orders will be transmitted via facsimile or a secure electronic format to the pharmacy c. Schedule II controlled substances require an original written prescription drug order manually signed by the authorized practitioner except in an emergency i. Immediate administration of the controlled substance is necessary for the proper treatment of the intended user ii. No appropriate alternative treatment is available iii. It is not reasonably possible for the prescribing practitioner to provide a written prescription drug order to the pharmacy. 4. When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. 5. All prescriptions and orders received by Rise Home Healthcare either verbally, in writing or electronically will be kept confidential. 6. When staff become aware of any medications or dietary supplements being used by a resident that are not included in the assessment, the information will be documented, and the RN will be notified. 7. Rise Home Healthcare has determined not to require a prescription for over-the- counter medications and dietary supplements. These medications will be included on the Medication Profile annually renewed by the physician." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			

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

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01910	Continued From page 145 a large portion or all of the residents). The findings include: R1 was admitted to the licensee on October 15, 2020, and received assisted living services. R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with dressing, haircare, grooming, toileting, bathing, medication reminders, treatment and exercises reminders, medication administration, hands-on assistance with transfers and mobility, personal laundry, housekeeping and linen change, and I am ok check service. R1's medication administration record (MAR) for the months of March, April, and May 2025 indicated R1 was taking the following medications: - alfuzosin 10 mg tab, take 1 tab once daily; - aspirin 81mg tab, 1 tab daily; - calcium carbonate 400-500mg tab, take 1 tab daily; - Certavite 1tab daily; - clobesatol propionate 0.05%, apply topically once daily; - esomeprazole magnesium 1 cap 20mg, take 1 cap daily; - gabapentin 100mg cap, take 1 cap at bedtime; - stiol respimat 2.5 micrograms (mcg) inhaler, inhale 2 puffs daily; - triamcinolone 0.5% cream 15gram apply topically to affected area three times daily; - acetaminophen 1tab 500mg take 1 tab every 4 hours for pain or fever as needed; - albuterol sulfate take 2 puffs twice a day as needed; and - carboxymethylcellulose sodium 0.5%, instill 1	01910			

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NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
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01910	Continued From page 146 drop into eye as needed twice daily as needed. The licensee's Discharge or Deceased Resident Roster dated July 5, 2022 [sic] indicated R1 was admitted to the licensee on August 20, 2023, and discharged on May 24, 2025. R1's record lacked evidence of documented disposition of medications for R1 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On May 28, 2025, at 2:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they were not sure if it was considered discharge or transfer since R1 was moved to a different facility under the same ownership. LALD/RN-D also stated they sent R1's medication with R1 to the new facility but they did not do medication disposition documentation. The licensee's Disposition and Disposal of Medications policy dated June 24, 2024, read, "1. Discontinued medications may be kept until the expiration dates if there is a possibility of resuming the medication. If not resumed before the expiration date, it will be disposed of according to this policy. 2. Unused portions of current medications being managed by the facility will be given to the resident or responsible party when the resident's service plan ends, medication management services are no longer provided under the service plan or upon discharge; and a note regarding this is placed in the clinical record. Medications for a resident who is deceased or that have been discontinued or expired may be provided for	01910			

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01910	Continued From page 147 disposal." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940			

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01940	Continued From page 148 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of one resident (R4) with a specialized diet and an adaptive device (hand cushion used to treat or prevent contractures). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. R4's After Visit Summary (AVS) from a clinic visit dated March 1, 2024, indicated R4's diet	01940			

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01940	Continued From page 149 instructions were, "easy to chew," and "thin liquids." R4's resident record lacked an assessment, service plan, or any record completed by the licensee. R4's record lacked prescriber orders for medications or treatments. The licensee had no written direction available to the unlicensed personnel regarding R4's care needs or information in the event of an emergency. On May 28, 2025, the surveyor observed R4 throughout the day. The surveyor observed R4 in their hospital bed and motorized wheelchair. The surveyor observed unlicensed personnel (ULP) provide services and cares for R4 which included a two-person transfer from their hospital bed to their wheelchair, two-person assisted change of clothing and brief, and a blended meal with feeding assistance. The surveyor observed R4 had contractures in bilateral legs, arms, and hands; R4 was completely dependent with their cares and activities of daily living (ADL). R4 was non-verbal and was unable to make their needs known. On May 28, 2025, at 2:06 p.m., the surveyor observed ULP-G and ULP-F conduct a two person transfer for R4 from their bed to their motorized wheelchair. The surveyor observed ULP-G apply cushions to R4's left hand, and stated the cushions helped to prevent contractures, and they kept them on R4's hands for 15 minutes every day. On May 28, 2025, at 2:14 p.m., the surveyor observed ULP-G use a blender to blend R4's lunch which included salmon, vegetables, and lettuce salad, combined.	01940			

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01940	Continued From page 150 R4's record lacked an Individualized Treatment and Therapy Plan to include the following required contents: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On May 27, 2025, at 12:50 p.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated they did not do any paperwork (including an assisted living contract, admission assessment, individual abuse prevention plan, medication management plan, treatment and therapy management plan and service plan) for R4's admission since there was no nurse or LALD at the facility when the resident moved in. On May 28, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated they had not been to the facility for the last three months as they were on maternity leave. CNS-C stated they were not aware of R4's admission. CNS-C stated, "I have	01940			

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01940	Continued From page 151 not been here for the last three months you guys [referring to the surveyors] came here yesterday and I was asked to come in today and I came in to learn more about them [referring to R4 and R5] today." On May 28, 2025, at 9:40 a.m., CNS-C stated they had not yet conducted a comprehensive assessment for R4 since their admission on May 25, 2025. CNS-C stated they had five days after a resident was admitted to complete admission assessments, obtain signed orders, and "things like that." CNS-C stated R4 did not have an assessment or service plan completed. CNS-C stated they were currently on maternity leave and May 28 was their first day back; they stated they only returned because of the survey. CNS-C stated LALD/RN-D was covering for them to complete nursing duties in their absence. The surveyor questioned how their ULP could effectively and safely provide cares for R4 if they had not conducted a nursing assessment or used the assessment to develop a service plan for the resident. CNS-C stated they were told the family for R4 had been teaching the ULPs how to care for R4. On May 28, 2025, at 10:46 a.m., LALD/RN-D stated ULP-G and ULP-H both worked as a personal care assistant (PCA) with R4 for approximately six months prior to their arrival to the licensee on May 25, 2025. LALD/RN-D stated both ULPs were hired by the licensee when R4 moved to the facility on May 25, 2025, to help care for them. On May 28, 2025, at 2:30 p.m., the surveyor observed ULP-G feed R4 the above-mentioned blended lunch. CNS-C stated R4 was on a pureed diet. The surveyor observed R4 swallow	01940			

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01940	Continued From page 152 without difficulty, no signs of coughing or aspiration were observed. On May 28, 2025, at 3:01 p.m., LALD/RN-D stated all they knew about R4 was that R4 was a stroke patient, on pureed diet, and R4 was at risk of choking. On May 28, 2025, at 4:11 p.m., owner/unlicensed personnel (O/ULP)-J stated he arranged for R4 to move into the facility on May 25, 2025. O/ULP-J stated LALD/RN-D was notified of the admission but it was on a weekend and holiday, so it was difficult for their admission to be completed. LALD/RN-D stated they were the only nurse for the facility while CNS-C was on maternity leave and did not have a backup nurse to assist them in CNS-C's absence. The licensee's Treatment and Therapy Management Policy dated June 24, 2024, indicated the licensee will use treatment and therapy protocols consistent with the current evidence-based practice standards and guidelines. The registered nurse is responsible for assessing and developing the treatment and therapy service plan for resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	01950			

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01950	Continued From page 153 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) were trained by a registered nurse (RN) and demonstrated competency prior to providing treatments. Additionally, the licensee failed to specify, in writing, specific instructions for the resident and document those instructions in the resident's record for one of one resident (R4) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01950			

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01950	Continued From page 154 R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. R4's resident record lacked an assessment, service plan, or any record completed by the licensee. R4's record lacked prescriber orders for medications or treatments. The licensee had no written direction available to the unlicensed personnel regarding R4's care needs or information in the event of an emergency. R4's After Visit Summary (AVS) from a clinic visit dated March 1, 2024, indicated R4's diet instructions were, "easy to chew," and "thin liquids." On May 28, 2025, at 2:06 p.m., the surveyor observed unlicensed personnel (ULP)-G apply an adaptive device (hand cushion used to treat or prevent contractures) to R4's left hand. ULP-G stated they kept them on R4's hands for 15 minutes every day. On May 28, 2025, at 2:14 p.m., the surveyor observed ULP-G blend R4's lunch in a blender which included salmon, mixed vegetables, and lettuce salad, combined.	01950			

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01950	Continued From page 155 On May 28, 2025, at 2:30 p.m., the surveyor observed ULP-G feed R4 the above-mentioned blended lunch. Clinical nurse supervisor (CNS)-C stated R4 was on a pureed diet. The surveyor observed R4 swallow without difficulty, no signs of coughing or aspiration. On May 28, 2025, at 9:40 a.m., CNS-C stated R4's family was teaching staff how to take care of R4. On May 28, 2025, at 10:46 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated ULP-G and ULP-H had worked with R4 as personal care assistants (PCA). LALD/RN-D stated ULP-G had worked as a PCA with R4 for the past 6 months; ULP-G and ULP-H were both hired since they knew how to take care of R4. LALD/RN-D stated neither ULP-G or ULP-H had been trained by a nurse at the licensee's facility; they were showing staff how to take care of R4 since they both had taken care of R4 in the past and were familiar with R4's treatments. The licensee's Treatment and Therapy Management Policy dated June 24, 2024, indicated the licensee will use treatment and therapy protocols consistent with the current evidence-based practice standards and guidelines. The registered nurse is responsible for assessing and developing the treatment and therapy service plan for resident. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950			

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01960	Continued From page 156	01960			
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration for one of one resident (R4) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was	01960			

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01960	Continued From page 157 non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. R4's resident record lacked an assessment, service plan, or any record completed by the licensee. R4's record lacked prescriber orders for medications or treatments. The licensee had no written direction available to the unlicensed personnel regarding R4's care needs or information in the event of an emergency. R4's After Visit Summary (AVS) from a clinic visit dated March 1, 2024, indicated R4's diet instructions were, "easy to chew," and "thin liquids." On May 28, 2025, at 2:06 p.m., the surveyor observed unlicensed personnel (ULP)-G apply an adaptive device (hand cushion used to treat or prevent contractures) to R4's left hand. ULP-G stated they kept them on R4's hands for 15 minutes every day. On May 28, 2025, at 2:14 p.m., the surveyor observed ULP-G blend R4's lunch in a blender which included salmon, mixed vegetables, and lettuce salad, combined. On May 28, 2025, at 2:30 p.m., the surveyor observed ULP-G feed R4 the above-mentioned blended lunch. Clinical nurse supervisor (CNS)-C stated R4 was on a pureed diet. The surveyor observed R4 swallow without difficulty, no signs of coughing or aspiration.	01960			

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01960	Continued From page 158 On May 29, 2025, at 11:10 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they were not documenting R4's treatments since they did not have orders for the treatments including the specialized diet and contracture cushions. LALD/RN-D stated they did not know if there were further treatments for R4 they should have been providing and documenting. The licensee's Treatment and Therapy Management Policy dated June 24, 2024, indicated each staff member who administers a treatment or therapy is responsible for documenting it in the clinical record. When a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered and any follow-up procedures provided to meet the resident's needs as documented in the care plan or treatment plan or as ordered by the authorized prescriber No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01970			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01970	Continued From page 159 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber's orders were in place for treatments for one of one resident with treatments (R4). 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: R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, completed by their waived services care coordinator/case manager, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. It indicated R4 required assistance with housekeeping, laundry, meal preparation and serving, dressing, grooming, bathing, eating, mobility, transfers, positioning, wheeling (in wheelchair), medication management, clinical monitoring, and behavioral support. R4's resident record lacked an assessment, service plan, or any record completed by the licensee. R4's record lacked prescriber orders for medications or treatments. The licensee had no written direction available to the unlicensed	01970			

Minnesota Department of Health

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01970	Continued From page 160 personnel regarding R4's care needs or information in the event of an emergency. R4's After Visit Summary (AVS) from a clinic visit dated March 1, 2024, indicated R4's diet instructions were, "easy to chew," and "thin liquids." On May 28, 2025, at 2:06 p.m., the surveyor observed unlicensed personnel (ULP)-G apply an adaptive device (hand cushion used to treat or prevent contractures) to R4's left hand. ULP-G stated they kept them on R4's hands for 15 minutes every day. On May 28, 2025, at 2:14 p.m., the surveyor observed ULP-G use a blender to blend R4's lunch which included salmon, vegetables, and lettuce salad, combined. On May 28, 2025, at 2:30 p.m., the surveyor observed ULP-G feed R4 the above-mentioned blended food. Clinical nurse supervisor (CNS)-C stated R4 was on a pureed diet. The surveyor observed R4 swallow without difficulty, no signs of coughing or aspiration. R4's record lacked prescriber orders for the hand contracture cushion or for mechanically pureed foods. On May 27, 2025, at 12:50 p.m., via telephone, licensed assisted living director/registered nurse (LALD/RN)-D stated they did not do any paperwork (including an assisted living contract, admission assessment, individual abuse prevention plan, medication management plan, treatment and therapy management plan and service plan) for R4's admission since there was no nurse or LALD at the facility upon the	01970			

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01970	Continued From page 161 resident's admission. On May 28, 2025, at 9:38 a.m., LALD/RN-D stated normally when they admit a new resident they ask for recent after visit summary, case workers assessment of the resident, health certification form and they would complete the uniform assessment tool, service plan and other paper works with in four days; based on the residents' background information. The surveyor inquired if they had gotten background information on R4. LALD/RN-D stated they did get background information form R4's family and the case worker, but they did not have any records, and they did not do the required official documentation. LALD/RN-D further stated R4's family communicated the resident's needs to the licensee over the phone. R4's family communicated that R4 had stroke, was nonverbal, bed bound, required pureed food, and total care. LALD/RN-D stated they did not have anything in writing other than R4's AVS. On May 28, 2025, at 9:54 a.m., LALD/RN-D stated this was the first time there had been a nurse at the facility since R4's admission. LALD/RN-D stated they were supposed to request treatment and medication orders from R4's doctor but they did not get that far. LALD/RN-D further stated that they were hoping to delay the admission of R4, but the facility owner did not take their recommendation and said it was OK to take the resident. On May 28, 2025, at 3:01 p.m., LALD/RN-D stated all they knew about R4 was that R4 was a stroke patient, on a pureed diet, and R4 was at risk of choking. On May 29, 2025, at 11:10 a.m., LALD/RN-D	01970			

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01970	Continued From page 162 stated they were not documenting R4's treatments since they did not have orders for the treatments including the mechanical diet and contracture cushion. LALD/RN-D stated they did not know if there were further treatments they should have been providing and documenting. The licensee's Treatment and Therapy Management Policy dated June 24, 2024, indicated the RN or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. Resident Name b. Description of the treatment or therapy to be provided c. Frequency d. Other pertinent information No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2025
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02310	Continued From page 163 resident (R4) with hospital bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: R4 was admitted to the licensee on May 25, 2025. R4's Support Plan dated November 26, 2024, indicated R4 had a diagnosis of a stroke. It indicated R4 was non-verbal, bedbound, and wheelchair bound. R4's resident record lacked an assessment or service plan completed by the licensee. R4's resident record lacked a bed rail assessment. On May 28, 2025, at 9:34 a.m., the surveyor observed R4 in their hospital bed which was set in the high position. The surveyor observed there was a half bed rail attached to the right side of the hospital bed positioned in the middle of the bed between the head of the bed and the foot of the bed. The surveyor wiggled and pulled on the bed rail which attached loosely to the bed. On May 28, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-C stated R4's family attached the bed rail to R4's hospital bed last night on May	02310			

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02310	Continued From page 164 27, 2025. CNS-C stated one of the nurses assessed the bed rail last night on May 27, 2025. The surveyor observed CNS-C look through their computer for a bed rail assessment; they stated a bed rail assessment was not completed. The surveyor requested R4's most recent nursing assessment; CNS-C stated R4 had not had an assessment of any kind completed since they were admitted on May 25, 2025. CNS-C stated R4 did not have a service plan completed. CNS-C stated R4 was the first resident they had ever had who had a bed rail. CNS-C stated they used to work at a hospital and was aware bed rails had requirements but was not sure how bed rails were handled in an assisted living facility setting. CNS-C stated they did not know the general requirements or measurements recommended by the Food and Drug Administration (FDA) for hospital beds. Licensed assisted living director/registered nurse (LALD/RN)-D stated they did not know what the requirements were for bed rails or bed rail assessments. The surveyor reviewed the Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) with CNS-C and LALD/RN-D to show them the required information and assessments for residents with bed rails; both stated they could not be sure if R4 could safely have a bed rail without a nursing assessment. The MDH website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated December 13, 2024, indicated, "Per FDA recommendations, the need for bed rails must be assessed on a "frequent, regular basis." At a minimum this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition."	02310			

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02310	Continued From page 165 Additionally, the MDH website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated December 13, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's hospital-style bed rails includes, but is not limited to: -purpose and intention of the bed rail; -condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -the resident's bed rail use/need assessment; -risk vs. benefits discussion (individualized to each resident's risks); -the resident's preferences; -installation and use according to manufacturer's guidelines; -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; -any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and -the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rail Use policy dated June 24, 2024, indicated:	02310			

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02310	Continued From page 166 "1. Before implementing side rails for a resident, the RN will conduct a side rail assessment that includes the following. -Level of mobility, including bed mobility -Ability to transfer in and out of bed without assistance -Vision -Level of consciousness -Level of cognition -Physical health status -Presence of orthostatic hypotension -Incontinence -Pain -Uncontrolled body movement 2. The RN will consider the resident and/or resident's representative's request for side rails during the evaluation. 3. Results of the side rail assessment will be documented in the clinical record. 4. The RN will discuss with the resident/resident's representative alternatives to the use of side rails. 5. A physical therapy evaluation may be obtained, as appropriate. 6. If the need for side rails is indicated and the resident/family agree to their use, the RN will provide education related to side rails. -Risks and benefits of the side rails will be discussed -If the manufacturer cannot be determined, this risk will be discussed with the resident and/or resident's representative or responsible party. 7. The RN will document the purpose of the side rails, the education provided and the discussion with the resident/resident's representative(s) regarding the risks and benefits of the side rails as well as the preferences of the resident. 8. The resident/resident's representative will co-sign the document agreeing to the benefits and risks of the side rails. 9. The RN is responsible to ensure that the side	02310			

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02310	Continued From page 167 rails in use are of a safe design and properly maintained. 10. Portable side rails will be used consistent with the manufacturer's recommendations. 11. The RN will verify that the side rails meet FDA guidelines and follow the manufacturer's recommendations related to the following: -The side rails, mattress and bed frame are compatible -The side rails are appropriate for the age, size and weight of the resident -The side rails are securely installed or attached to the bedframe according to the manufacturer's recommendations for the particular bed frame and side rails used -The manufacturer's guidelines should be accessible -As indicated, additional information will be obtained from the Consumer Product Safety Commission (CSPC) related to side rails and any recalls 12. The need for side rails will be reassessed and the side rails inspected as needed, but not less than every 90 days. The ongoing assessment includes a consideration of the following -Inspecting the side rails for any functional problems or maintenance issues -Lowering one or more sections of the side rail(s) -Verifying that the mattress is the proper size and prevents entrapment between the mattress and rail -Gaps between the mattress and side rails are reduced -Assuring that the side rails are still installed correctly and that there are no areas for possible entrapment and falls -The side rails are still appropriate to the bed and the resident's 13. Should any episode of entrapment or	02310			

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02310	Continued From page 168 near-entrapment** occur, an immediate (within minutes) reassessment and re-evaluation of the equipment will be conducted to address and correct the cause of the episode. 14. Documentation regarding the side rails will include the following: -The measurements -Installation -Condition -Results of the physical inspection of the side rails and mattress for areas of entrapment and stability -Any other information to mitigate safety risks 15. Should any episode of entrapment or near-entrapment occur, an immediate (within minutes) reassessment and re-evaluation of the equipment will be conducted to address and correct the cause of the episode." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Rise Home Health Care
547 Continental Drive
New Brighton, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 36117

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1043251045
Inspection Type: Follow-up - Single
Date: 6/5/2025 Time: 3:57:15 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 5
Total Priority 3 Orders: 8
Delivery:

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

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

COMMENT: REPEAT FROM 7/5/22, REISSUED 3/3/25. NO CFPM EMPLOYED, ONLY COURSE CERTIFICATE IS AVAILABLE. ADVISED STAFF TO RE-TAKE THE EXAM AND SEND CERTIFICATE TO THE STATE WITHIN 6 MONTHS OF PASSING. INFO PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

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

COMMENT: ISSUED 3/3/25. NO ILLNESS LOG IN USE. ADVISED STAFF TO RECORD EMPLOYEES WHO CALL IN OR GO HOME SICK. LOG PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

New Order: 2-500 Cleanup of Vomiting and Diarrheal Events

2-501.11 Priority Level: Priority 2 CFP#: 5

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

COMMENT: ISSUED 3/3/25. NO CLEAN UP PROCEDURES OR KIT AVAILABLE. ADVISED STAFF TO PROVIDE AT LEAST ONE OPTION AND TRAIN ALL EMPLOYEES. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

New Order: 4-100 Equipment Construction Materials4-101.17 *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0490* Discontinue using wood and wood wicker as a food contact surface.

COMMENT: ISSUED 3/3/25. FACILITY USES WOODEN CUTTING BOARDS - ONE IS A UNDER COUNTER PULL OUT UNDERNEATH THE MICROWAVE. ADVISED STAFF TO PROVIDE A CUTTING BOARD THAT IS NOT MADE OF AN ABSORBENT MATERIAL (EX: PLASTIC, ETC). COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 4-200 Equipment Design and Construction**4-201.11GMN *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0506G* Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: ISSUED 3/3/25. PER STAFF, LEFTOVER FOOD MADE IN HOUSE IS KEPT FOR ADDITIONAL DAYS. ADVISED STAFF TO DISCONTINUE PRACTICE AND DISCARD LEFTOVERS BY END OF DAY. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 4-200 Equipment Design and Construction**4-204.112A *Priority Level: Priority 3 CFP#: 36**MN Rule 4626.0620A* Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: ISSUED 3/3/25. KITCHEN FRIDGE DOES NOT HAVE A DIGITAL TEMPERATURE READING AND NO THERMOMETER WAS OBSERVED WITHIN UNIT. ADVISED STAFF TO PROVIDE. PLACE THERMOMETER AT FRONT OF TOP SHELF. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 4-300 Equipment Numbers and Capacities**4-302.12B *Priority Level: Priority 2 CFP#: 36**MN Rule 4626.0705B* Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: ISSUED 3/3/25. NO THERMOMETER AVAILABLE ON SITE. ADVISED STAFF TO PROVIDE A THIN PROBE THERMOMETER TO MEASURE INTERNAL TEMPERATURES OF FOOD. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 4-300 Equipment Numbers and Capacities**4-302.13B *Priority Level: Priority 2 CFP#: 48**MN Rule 4626.0710B* Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: ISSUED 3/3/25. NO TEST KIT AVAILABLE ON SITE. ADVISED STAFF TO PROVIDE AND MAINTAIN AN IRREVERSIBLE THERMOMETER OR THERMOLABELS TO MEASURE UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

New Order: 4-300 Equipment Numbers and Capacities4-302.14 *Priority Level: Priority 2 CFP#: 48**MN Rule 4626.0715* Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: ISSUED 3/3/25. FACILITY USES CHLORINE. NO TEST KIT AVAILABLE. ADVISED STAFF TO PROVIDE AND MAINTAIN (REFER TO EXPIRATION DATE). COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 4-500 Equipment Maintenance and Operation**4-501.11AB *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0735AB* All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: ISSUED 3/3/25. PER STAFF, DISH MACHINE IS NOT WORKING AND IS IN NEED OF REPAIR/REPLACEMENT. ADVISED STAFF TO WASH DISHWARE USING 3 COMPARTMENT SET UP UNTIL UNIT IS REPAIR/REPLACED. SEE COMMENT SECTION FOR UPDATED INFORMATION. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 4-900 Protecting Clean Items**4-903.11A *Priority Level: Priority 3 CFP#: 44**MN Rule 4626.0955A* Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

COMMENT: ISSUED 3/3/25. PACK OF SINGLE USE PLATES STORED ON FLOOR OF OUTDOOR DECK. ADVISED STAFF TO RELOCATE ITEMS INSIDE AND AT LEAST 6 INCHES OFF THE FLOOR. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 6-300 Physical Facility Numbers and Capacities**6-301.14A *Priority Level: Priority 3 CFP#: 10**MN Rule 4626.1457* Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: ISSUED 3/3/25. BATHROOM MISSING HANDWASHING SIGN REMINDER. ADVISED STAFF TO POST. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control**6-501.11 *Priority Level: Priority 3 CFP#: 55**MN Rule 4626.1515* Maintain the physical facilities in good repair.

COMMENT: ISSUED 3/3/25. DRAWER TO RIGHT SIDE OF STOVE OBSERVED TO BE MISSING THE COVER AND EXPOSES UNSEALED WOOD. ADVISED STAFF TO REINSTALL COVER. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***New Order: 7-100 Toxic Labeling**7-102.11 *Priority Level: Priority 2 CFP#: 28**MN Rule 4626.1595* Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

COMMENT: ISSUED 3/3/25. SANI SPRAY BOTTLE OBSERVED UNLABELED. ADVISED STAFF TO PROVIDE AND MAINTAIN LABEL. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

! New Order: 7-200 Toxic Supplies and Applications7-204.11 *Priority Level: Priority 1 CFP#: 28*

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT: ISSUED 3/3/25. FACILITY USES CHLORINE FOR SANITIZER. SANI SPRAY BOTTLE MEASURED +200 PPM. ADVISED STAFF TO MAINTAIN CONCENTRATION BETWEEN 50-100 PPM. CORRECTED ON SITE TO 100 PPM. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Food & Beverage General Comment

Follow-up report written for compliance on repairing/replacing dish machine. Per email received by Naeema (PIC) with Rise Home Health Care on 4/22/2025., PIC stated that the dish machine was replaced. Sanitarian requested for PIC to run a dish machine cycle with a test kit to measure the utensil surface temperature for verification. Sanitarian was unable to verify working dish machine as test results were not provided as requested.

Initial 3/3/2025 inspection was completed with Dee Mosissa as the lead Health Regulation Division Nurse Evaluator completing the site survey. All items on the report were discussed with Hawa Hersi and other present employees onsite at the time.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day.

This facility has a residential kitchen with residential equipment, wooden cabinetry, and linoleum flooring.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1043251045 from 6/5/2025

Establishment Representative


Blia Lor,
Public Health Sanitarian 1

651-355-0641
blia.lor@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
Rise Home Health Care 547 Continental Drive New Brighton, MN 55112 Ramsey County Parcel: Phone:	License: HFID 36117 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F1043251052 Inspection Type: Follow-up - Single Date: 6/11/2025 Time: 1:40:20 PM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 2</u> <u>Total Priority 2 Orders: 4</u> <u>Total Priority 3 Orders: 7</u> <u>Delivery:</u>

Previous Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3 CFP#: 2*

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

COMMENT: REPEAT FROM 7/5/22, REISSUED 3/3/25. NO CFPM EMPLOYED, ONLY COURSE CERTIFICATE IS AVAILABLE. ADVISED STAFF TO RE-TAKE THE EXAM AND SEND CERTIFICATE TO THE STATE WITHIN 6 MONTHS OF PASSING. INFO PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

! Previous Order: 2-200 Employee Health

2-201.11C *Priority Level: Priority 1 CFP#: 3*

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

COMMENT: ISSUED 3/3/25. NO ILLNESS LOG IN USE. ADVISED STAFF TO RECORD EMPLOYEES WHO CALL IN OR GO HOME SICK. LOG PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Previous Order: 2-500 Cleanup of Vomiting and Diarrheal Events

2-501.11 *Priority Level: Priority 2 CFP#: 5*

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

COMMENT: ISSUED 3/3/25. NO CLEAN UP PROCEDURES OR KIT AVAILABLE. ADVISED STAFF TO PROVIDE AT LEAST ONE OPTION AND TRAIN ALL EMPLOYEES. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Previous Order: 4-100 Equipment Construction Materials4-101.17 *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0490* Discontinue using wood and wood wicker as a food contact surface.

COMMENT: ISSUED 3/3/25. FACILITY USES WOODEN CUTTING BOARDS - ONE IS A UNDER COUNTER PULL OUT UNDERNEATH THE MICROWAVE. ADVISED STAFF TO PROVIDE A CUTTING BOARD THAT IS NOT MADE OF AN ABSORBENT MATERIAL (EX: PLASTIC, ETC). COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***Previous Order: 4-200 Equipment Design and Construction**4-201.11GMN *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0506G* Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: ISSUED 3/3/25. PER STAFF, LEFTOVER FOOD MADE IN HOUSE IS KEPT FOR ADDITIONAL DAYS. ADVISED STAFF TO DISCONTINUE PRACTICE AND DISCARD LEFTOVERS BY END OF DAY. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***Previous Order: 4-200 Equipment Design and Construction**4-204.112A *Priority Level: Priority 3 CFP#: 36**MN Rule 4626.0620A* Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: ISSUED 3/3/25. KITCHEN FRIDGE DOES NOT HAVE A DIGITAL TEMPERATURE READING AND NO THERMOMETER WAS OBSERVED WITHIN UNIT. ADVISED STAFF TO PROVIDE. PLACE THERMOMETER AT FRONT OF TOP SHELF. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***Previous Order: 4-300 Equipment Numbers and Capacities**4-302.12B *Priority Level: Priority 2 CFP#: 36**MN Rule 4626.0705B* Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: ISSUED 3/3/25. NO THERMOMETER AVAILABLE ON SITE. ADVISED STAFF TO PROVIDE A THIN PROBE THERMOMETER TO MEASURE INTERNAL TEMPERATURES OF FOOD. COMPLY WITH ABOVE RULE.

*Comply By: 6/5/2025 Originally Issued On: 6/5/2025***Previous Order: 4-300 Equipment Numbers and Capacities**4-302.14 *Priority Level: Priority 2 CFP#: 48**MN Rule 4626.0715* Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: ISSUED 3/3/25. FACILITY USES CHLORINE. NO TEST KIT AVAILABLE. ADVISED STAFF TO PROVIDE AND MAINTAIN (REFER TO EXPIRATION DATE). COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Previous Order: 4-900 Protecting Clean Items4-903.11A *Priority Level: Priority 3 CFP#: 44*

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

COMMENT: ISSUED 3/3/25. PACK OF SINGLE USE PLATES STORED ON FLOOR OF OUTDOOR DECK. ADVISED STAFF TO RELOCATE ITEMS INSIDE AND AT LEAST 6 INCHES OFF THE FLOOR. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Previous Order: 6-300 Physical Facility Numbers and Capacities6-301.14A *Priority Level: Priority 3 CFP#: 10*

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: ISSUED 3/3/25. BATHROOM MISSING HANDWASHING SIGN REMINDER. ADVISED STAFF TO POST. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Previous Order: 6-500 Physical Facility Maintenance/Operation and Pest Control6-501.11 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: ISSUED 3/3/25. DRAWER TO RIGHT SIDE OF STOVE OBSERVED TO BE MISSING THE COVER AND EXPOSES UNSEALED WOOD. ADVISED STAFF TO REINSTALL COVER. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Previous Order: 7-100 Toxic Labeling7-102.11 *Priority Level: Priority 2 CFP#: 28*

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

COMMENT: ISSUED 3/3/25. SANI SPRAY BOTTLE OBSERVED UNLABELED. ADVISED STAFF TO PROVIDE AND MAINTAIN LABEL. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

! Previous Order: 7-200 Toxic Supplies and Applications7-204.11 *Priority Level: Priority 1 CFP#: 28*

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT: ISSUED 3/3/25. FACILITY USES CHLORINE FOR SANITIZER. SANI SPRAY BOTTLE MEASURED +200 PPM. ADVISED STAFF TO MAINTAIN CONCENTRATION BETWEEN 50-100 PPM. CORRECTED ON SITE TO 100 PPM. COMPLY WITH ABOVE RULE.

Comply By: 6/5/2025 Originally Issued On: 6/5/2025

Food & Beverage General Comment

Follow-up report written for compliance on repairing/replacing dish machine. Working dish machine and dish machine test kit were verified via email on 6/11/2025.

Initial 3/3/2025 inspection was completed with Dee Mosissa as the lead Health Regulation Division Nurse Evaluator completing the site survey. All items on the report were discussed with Hawa Hersi and other present

employees onsite at the time.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day.

This facility has a residential kitchen with residential equipment, wooden cabinetry, and linoleum flooring.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1043251052 from 6/11/2025

Naeema Saleh
PIC



Blia Lor,
Public Health Sanitarian 1
651-355-0641
blia.lor@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 7, 2025

Licensee

Rise Home Health Care

547 Continental Drive

New Brighton, MN 55112

RE: Project Number(s) SL36117016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$3,000.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

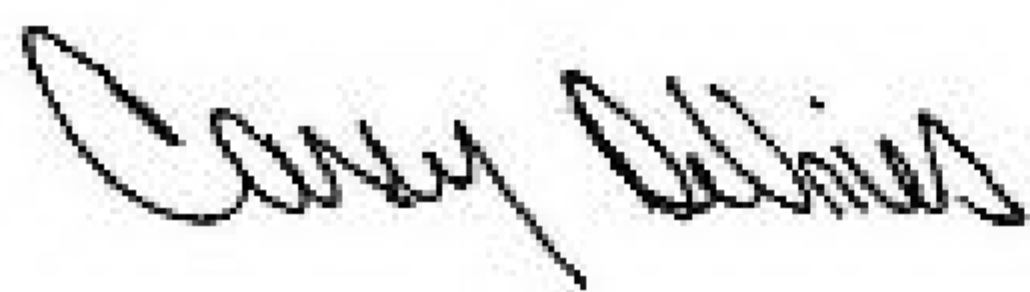
may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36117016-0 On March 3, 2025, through March 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of them received services under the Assisted Living license. An immediate correction order was identified on March 3, 2025, issued for SL36117016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on March 4, 2025, issued for SL36117016-0, tag	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
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0 000	Continued From page 1 identification 0775. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(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
0 340	Continued From page 2 licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0470, 0680) for a survey completed on July 7, 2022. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 3, 2025, at 10:30 a.m., clinical nurse supervisor (CNS)-C stated the licensee was familiar with current minimum assisted living requirements. The licensee lacked documentation to indicate correction orders previously cited on July 7, 2022, were in full compliance with assisted living statutes. On March 4, 2025, at 3:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did make the corrections following their receipt of the survey results from the survey concluded on July 7, 2022, however, correction orders 0470 and 0680 were reissued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
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0 345	Continued From page 3	0 345			
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to make available the most recent plan of correction in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders, after a survey conducted July 5, 2022, through July 7, 2022. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 345			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
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0 345	Continued From page 4 On March 4, 2025, at 3:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did make corrections to orders following the survey mentioned above but they did not have plan of correction to document the actions taken by the facility to comply with the correction orders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;	0 470			

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NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
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0 470	Continued From page 5 (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed review the staffing plan at least twice a year to determine staffing levels to meet the needs of all residents (as indicated in Minnesota Administrative Rule 4659.0180), and failed to ensure the required staffing schedule was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of four residents and had a current census of three residents. POSTING On March 3, 2025, at 12:12 p.m., during a facility tour the surveyor observed the facility lacked a posted staff schedule. On March 3, 2025, at 12:13 p.m., licensed	0 470			

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0 470	Continued From page 6 assisted living director/registered nurse (LALD/RN)-D stated they wrote the daily staffing schedule on a white board and pointed to a small whiteboard in the kitchen that contained a food menu. LALD/RN-D stated they did not know who wrote the menu on the white board and stated that was where they wrote the daily staffing schedule. STAFFING PLAN REVIEW On March 3, 2025, at approximately 1:00 p.m., LALD/RN-D provided the surveyor with an undated staffing plan. On March 3, 2025, at 1:30 p.m., LALD/RN-D, stated the licensee did not have a staffing plan previously and the undated staffing plan mentioned above was created last year. LALD/RN-D further stated the staffing plan was reviewed once yearly. The licensee's Staffing policy dated June 24, 2024, indicated the Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. The staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

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0 480	Continued From page 7 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480			

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0 480	Continued From page 8 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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0 480	Continued From page 9 to the FBEIR for any compliance.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Health Facility Complaints (OHFC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 550			

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0 550	Continued From page 10 The findings include: On March 3, 2025, at approximately 12:10 p.m., during a facility tour, the surveyor observed contact information for the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center, posted on the wall by the living room. The surveyor observed the licensee lacked the contact information for: - OHFC. On March 3, 2025, at approximately 12:10 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they were not aware of the requirement to post OHFC's contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors.	0 570			

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0 570	Continued From page 11 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 March 3, 2025, at approximately 12:10 p.m., during a facility tour the surveyor observed the facility lacked a posted assisted living license. On March 3, 2025, at 12:11 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they took the assisted living license posting down when it expired. LALD/RN-D also stated they had not received the new assisted living license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
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	0 580			

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0 580	Continued From page 12 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 activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 March 3, 2025, at approximately 10:30 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-D stated the licensee had a quality management program and would provide it to the surveyor. On March 3, 2025, at approximately 2:20 p.m., LALD/RN-D provided the surveyor with a copy of quality management meeting minutes dated February 15, 2021. LALD/RN-D stated the licensee had not held a quality management meeting recently. The licensee's Quality Improvement policy, dated June 24, 2024, indicated documentation of	0 580			

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0 580	Continued From page 13 Quality Improvement activities would be maintained and updated as needed, but not less than annually. The licensee would maintain documented quality improvement program for at least for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced	0 650			

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0 650	Continued From page 14 by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-B, ULP-E, clinical nurse supervisor (CNS)-C). 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 the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on August 8, 2020, to provide direct care to residents. ULP-B's employee record included an Annual Performance Evaluation dated August 1, 2022, through August 1, 2023. ULP-E ULP-E was hired on April 20, 2020, to provide direct care to residents. ULP-E's employee record included an Annual Performance Evaluation dated December 31, 2022, through December 31, 2023. CNS-C CNS-C was hired on June 22, 2020, to provide oversight to direct care staff. CNS-C, ULP-B, and ULP-E's employee record	0 650			

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0 650	Continued From page 15 lacked documentation of annual performance reviews that identified areas of improvement needed and training needs. On March 4, 2025, at 1:37 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they have not done annual performance review for any employees in 2024. LALD/RN-D also stated they were unable to find any performance evaluation completed for CNS-C and did not know why it was not completed. The licensee's Performance Evaluation policy dated June 24, 2024, indicated a performance evaluation will be conducted for all staff providing assisted living services at least annually and documentation of the annual performance evaluation will be maintained in the personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680			

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0 680	Continued From page 16 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain an emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post the EPP in a prominent area. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated Emergency Preparedness plan lacked evidence of the following required content: - patient population; - process for cooperation and collaboration with	0 680			

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0 680	Continued From page 17 local, tribal, regional, State and Federal EP to maintain integrated response; - role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - development of communication plan and annual review of the plan; - methods of sharing information; - sharing information on occupancy/needs; - communication plan including all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, and volunteers; - communication plan must include contact information for the following: Federal, State, tribal, regional & local EP staff, state licensing and certification agency, Office of Ombudsman for Long-Term Care; - annual review of the EPP; and - quarterly review of missing resident. On March 4, 2025, at 12:39 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the EPP was kept in locked in a filing cabinet in the living room. On March 4, 2025, at 1:35 p.m., LALD/RN-D stated they reviewed the missing resident policy and the EPP yearly, but they did do documentation of the review. LALD/RN-D also stated they were not aware the EPP was missing required topics. On March 4, 2025, at 2:25 p.m., LALD/RN-D stated they did not have subsistence needs. LALD/RN-D also stated the EPP is new that might be why they were missing some staff and they stated they are updating the EPP.	0 680			

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0 680	Continued From page 18 The licensee's Emergency Preparedness policy dated June 24, 2024, the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated June 24, 2024, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly and changes to the plan will be documented. Minnesota Administrative Rule 4659.0110, Subp 4. dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=G	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 775			

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NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(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
0 775	Continued From page 19 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 4, 2025, at 10:20 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. The egress windows in resident bedrooms rooms were opened by ULP-E and measured by the surveyor. Both windows in occupied resident sleeping room 4 did not meet the minimum requirements for safe egress. Egress Window Measurements Resident sleeping room 4 - the clear open area of window #1 measured 19.5 inches width, 31 inches height, with a total clear area of 604.5 square inches. The clear open area of window #2 measured 15.5 inches width, 32.75 inches height, with a total clear area of 507.624 square inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). During the facility tour interview, ULP-E verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate In addition, on March 4, 2025, at 10:20 a.m., the surveyor toured the facility with ULP-E. During the facility tour, the surveyor observed the following: Carbon Monoxide Alarms The carbon monoxide alarm installed outside of the occupied resident sleeping rooms in the basement did not work when tested by ULP-E. During the facility tour interview, ULP-E stated this carbon monoxide alarm had not been	0 775			

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0 775	Continued From page 20 maintained. Operable carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. Obstructed Egress - The bed headboard obstructed the egress window in occupied resident room 1. - The path to the egress window was obstructed by an accumulation of personal items stored on the floor in occupied resident room 2. During the facility tour interview, ULP-E verified the obstructed egress observations. Egress windows must be accessible at all times and maintained free of obstruction. Clothes Dryer Maintenance There was an accumulation of lint behind the clothes dryer in the basement, creating a fire hazard. During the facility tour interview, ULP-E verified the above listed observation.	0 775			
0 790 SS=D	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	0 790			

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0 790	Continued From page 21 failed to maintain a portable fire extinguisher as required by statute. This had the potential to directly affect 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 4, 2025, at 10:20 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. During the tour of the main floor level, the surveyor observed a tag or label was not attached to the installed portable fire extinguisher recording annual maintenance had been performed by certified service personnel. The bottom of the fire extinguisher was dated stamped 2022. During the facility tour interview, ULP-E verified annual maintenance had not been completed on this fire extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800			

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0 800	Continued From page 22 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect more than a limited number of 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 4, 2025, at 10:20 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. During the tour the surveyor observed the following: - A door was installed between occupied resident bedroom 1 and the attached garage. When ULP-E opened the door, this door did not self-close and positively latch. - The handrail was loose and one rail bracket had become disconnected for the stairs leading from basement bedroom 1 into the attached garage. - The bottom of the door was chipped and peeling for the shared resident bathroom in the basement.	0 800			

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0 800	Continued From page 23 - In the basement laundry/mechanical room: The sliding door was off the track. One section of drywall was water damaged. - The carpet on the front steps was peeling, creating a trip/fall hazard. During the facility tour interview, ULP-E verified the above listed physical environment observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810			

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0 810	Continued From page 24 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 4, 2025, unlicensed personnel (ULP)-E 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 fire safety and evacuation plan (FSEP) was not located in a central location for all staff accessibility. ULP-E stated during an interview on March 4, 2025, at 12:45 p.m., that the FSEP was located inside a locked cabinet in the living room office. Record review of the available documentation	0 810			

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0 810	Continued From page 25 indicated the licensee failed to develop the FSEP evident by the following: - The evacuation floor plan was not drawn accurately to scale. FSEP floor plans shall be easy to read and readily understandable by the building occupants in the event of an emergency. - The FSEP floor plan did not include room numbers identifying the resident sleeping rooms. On March 4, 2025, at 10:20 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. During the tour, the surveyor observed numbers were posted at the doors for each resident sleeping room. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan and correspond with the numbers installed at the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. - The FSEP floor plan did not label the main exit for the facility. Exit labels are required to be included on the floor plan in order to direct occupants to the exits in the event of an emergency. Record review of the available documentation indicated the licensee had not developed and maintained the FSEP with procedures specific to the facility and the building occupants. The FSEP had been created using templates from third party providers. - The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP inaccurately directed the building occupants to pull the nearest fire alarm. Pull fire alarms were not installed at this facility.	0 810			

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0 810	Continued From page 26 - The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. - The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by no procedures in the plan. Record review of the available documentation indicated the licensee had not maintained an accurate FSEP. The FSEP included a fire safety policy dated June 24, 2024. This policy identified portable fire extinguisher installation locations in the hallway on both floor levels of the home. A fire extinguisher was not installed in the basement. During an interview on February 4, 2025, at 12:45 p.m., ULP-E verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provided fire safety and evacuation training to residents at least once per year as evident by the lack of documentation. No training records were provided. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by a review of records lacking the required frequency. A fire evacuation plan training record was provided with employee names listed. The training was completed in August 2022. No additional training records were provided. During an interview on February 4, 2025, at 12:45 p.m., ULP-E verified the training frequencies were not met. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per	0 810			

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0 810	Continued From page 27 year, per shift with at least one evacuation drill every other month as evident by a review of completed fire drill logs. Five fire drills were recorded in 2024. Drills were completed in January, March, April, May, and November. The time or shift of the April and November drills had not been recorded. Night shift drills were not recorded in 2024. No drill records for 2025 were provided. During an interview on February 4, 2025, at 12:45 p.m., ULP-E verified the evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a	0 910			

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0 910	Continued From page 28 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 the residents). The findings include: R1 R1 was admitted to the licensee on October 15, 2020, and received assisted living services. R1's Assisted Living Contract signed on August 20, 2021, lacked the following required content: - in a conspicuous place and manner on the contract the legal name and Health Facility Identification number (HFID#) of the licensee; and - name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's Assisted Living Contract signed on July 8, 2022, lacked the following required content: - in a conspicuous place and manner on the contract the legal name and Health Facility Identification number (HFID#) of the licensee; and	0 910		

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0 910	Continued From page 29 - name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. R3 R3 was admitted to the licensee on September 12, 2023, and received assisted living services. R3's Assisted Living Contract signed on September 12, 2023, lacked the following required content: - in a conspicuous place and manner on the contract the legal name and Health Facility Identification number (HFID#) of the licensee; and - name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. On March 4, 2025, at 1:48 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they forgot to put the licensee's HFID and the above-mentioned information on the contract for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 910			

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0 910	Continued From page 30 (21) days	0 910			
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 include the required statutory	0 950			

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0 950	Continued From page 31 language giving residents the right to identify a designated representative in writing in the contract and failed to provide the required verbatim notice on its own separate page for three of three residents (R1, R2, R3). 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 the residents). The findings include: R1 R1 was admitted to the licensee on October 15, 2020, and received assisted living services. R1's Assisted Living Contract signed on August 20, 2021. R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's Assisted Living Contract signed on July 8, 2022. R3 R3 was admitted to the licensee on September 12, 2023, and received assisted living services. R3's Assisted Living Contract signed on September 12, 2023. The licensee's Assisted Living Contract form utilized for the above listed residents lacked the	0 950			

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0 950	Continued From page 32 required verbatim "right to designate a representative for certain purposes" notice on a document separate from the contract. On March 4, 2025, at 1:51 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they were not aware of the requirement to include "right to designate a representative for certain purposes" notice as part of the assisted living contract and on a document separate from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290			

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01290	Continued From page 33 Based on observation, interview, and record review, the licensee failed to re-run a COVID-19 expired background study (BGS) in NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) and failed to ensure the BGS was affiliated to the licensee's health facility identification number (HFID) for two of seven employees (unlicensed personnel (ULP-A, ULP-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's HFID was 36117. The licensee had access to another HFID in NETSTudy 2.0 for a closed comprehensive home care license, HFID 35515. ULP-A ULP- A was hired on July 15, 2020, to provide direct cares and services to residents. The licensee's work schedule for March 1, 2025, through March 31, 2025, indicated ULP-A was scheduled to work morning-shifts (8:00 a.m. to 8:00 p.m.) on Monday March 3, 2025, and 9:00 a.m., to 12:30 a.m., on Monday, March 24, 2025. The licensee's NETstudy2.0 roster printed on March 3, 2025, indicated ULP-A's BGS was	01290			

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01290	Continued From page 34 affiliated to the licensee's previous HFID 35515. The "Eligible - COVID-19 Study" status for the BGS was expired on December 31, 2022. The licensee failed to submit a new BGS for ULP-A after the COVID-19 eligible status had expired or affiliate a BGS to HFID 36117. ULP-B ULP-B was hired on July 8, 2020, to provide direct cares and services to residents. The licensee's work schedule for March 1, 2025, through March 31, 2025, indicated ULP-B was not scheduled to work for the month of March 2025. The licensee's NETstudy2.0 roster printed on March 3, 2025, indicated ULP-B's BGS was affiliated to the licensee's previous HFID 35515. The "Eligible - COVID-19 Study" status for the BGS was expired on December 31, 2022. The licensee failed to submit a new BGS for ULP-B after the COVID-19 eligible status had expired or affiliate a BGS to HFID 36117. On March 3, 2025, at 10:10 a.m., ULP-B opened the door for the surveyor and stated the door bell was not working and they did not hear a knock on the door. On March 3, 2025, at 10:15 a.m., the surveyor observed ULP-B leave the facility with R3 to an appointment. On March 3, 2025, at 2:45 p.m., licensed assisted living director (LALD)-D stated ULP-B was not scheduled to work as they were on a leave of absence. On March 3, 2025, at 2:51 p.m., LALD-D stated	01290			

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01290	Continued From page 35 they were not aware ULP-A and ULP-B's BGS was expired until today. On March 3, 2025, at 3:25 p.m., LALD-D stated both ULPs worked independently with residents without supervision. On March 3, 2025, LALD-D stated the licensee's scheduling system had completely erased ULP-B. LALD-D further stated they did not know why the system erased ULP-B and they would need to contact the vendor. The licensee's undated Background studies Policy indicated, " POLICY: Facility requires background screening to be completed on all employees, contractors, and regularly scheduled volunteers. Unwillingness to consent to the background study will result in withdrawal of the offer of employment. Results of the background studies are confidential and are retained in confidential employee files. Employees will not be able to start working with residents until the background check clearance has been received by the facility. PURPOSE: To provide a mechanism where background studies are completed on employees, contractors and volunteers [sic] To provide increased safety for residents of the Facility [sic] To reduce risk to the Facility." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01470 SS=F	144G.63 Subd. 2 Content of required orientation	01470			

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01470	Continued From page 36 (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 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 staff member 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	01470			

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01470	Continued From page 37 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-B, ULP-E, clinical nurse supervisor (CNS)-C). 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:	01470			

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01470	Continued From page 38 ULP-B ULP-B was hired on August 8, 2020, to provide direct care to residents. ULP-E ULP-E was hired on April 20, 2020, to provide direct care to residents. CNS-C CNS-C was hired on June 22, 2020, to provide oversight to direct care staff. CNS-C, ULP-B and ULP-E's employee records lacked evidence of orientation to assisted living regulations for the following topic: - review of provider's policies and procedures; - review of types of assisted living services the employee will provide and providers scope of license; - overview of assisted living statutes; and - consumer advocacy service. On March 6, 2025, at 9:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did not know why the above-mentioned employees were missing the above-mentioned topics of orientation. LALD/RN-D further stated they had never heard of the consumer advocacy services training. The license's Staff Orientation and Education policy dated June 24, 2024, indicated all staff providing assisted living services would be required to complete the organization's orientation program before providing direct care to residents. The policy did not include contents of the orientation. No further information was provided.	01470			

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01470	Continued From page 39	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500			

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01500	Continued From page 40 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (clinical nurse supervisor (CNS)-C). 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 the potential to affect a large portion or all of the residents).	01500			

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01500	Continued From page 41 The findings include: CNS-C was hired on June 22, 2020, to provide oversight to direct care staff. CNS-C's employee record included the following annual training: - 0.75 hours of training on effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders completed on April 1, 2024. CNS-C's employee record lacked the following annual training topics completed within the last 12 months: - assisted living bill of rights completed on August 1, 2023; - infection control techniques completed on August 1, 2023; - principles of person-centered planning and service delivery completed on August 1, 2023; - and - vulnerable adult completed on August 1, 2023. On March 4, 2025, at 1:42 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they forgot to assign the remainder of CNS-C'S dementia and annual trainings. The licensee's Staff Orientation and Education dated June 24, 2024, indicated all staff providing assisted living services will complete at least eight hours of training for each 12 months of employment. No further information was provided.	01500			

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01500	Continued From page 42	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (clinical nurse supervisor (CNS)-C) received at least eight hours of initial dementia care training	01530			

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01530	Continued From page 43 within 120 working hours of their employment start date, and two hours of dementia training annually. 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 the potential to affect a large portion or all of the residents). The findings include: CNS-C was hired on June 22, 2020, to provide oversight to direct care staff. CNS-C's employee record included an Educare (online training platform) training document which indicated CNS-C had 0.75 hours of dementia training completed on October 28, 2020, 3.5 hours of dementia training completed on August 1, 2023, and 0.75 hours of dementia training completed in April, 2024, for a total of 5 hours which was 3 hours short of the required eight hours of dementia training required to be completed within 120 working hours of the CNS's employment start date. CNS-C's employee record also lacked 2 hours of annual dementia training in 2022, 1.25 hours in 2023 and 2024. On March 4, 2025, at 1:42 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they forgot to assign CNS-C'S dementia and annual trainings. LALD/RN-D also stated all employees had worked for the licensee for more than 160 hours.	01530			

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01530	Continued From page 44 The licensee's Dementia Education policy dated June 24, 2024, indicated supervisors of direct care employees will have at least eight hours of initial dementia training within 120 working hours of the employment start date; and two hours education on topics related to dementia care for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620			

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01620	Continued From page 45 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3 admitted to the licensee on September 12, 2023, and began receiving assisted living services. R3's diagnosis included depressive disorder. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, housekeeping, linen change, and socialization. R3's record included uniform assessment tool completed for R3's initial admission assessment and 90-day nursing assessments. R3's 90-day nursing assessment was last completed on September 20, 2024. R3's record lacked a 90-day assessment which was due to be completed on	01620			

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01620	Continued From page 46 December 19, 2024. On March 4, 2024, at 1:54 p.m., clinical nurse supervisor (CNS)-C stated they recalled having done R3's assessment but they did not document it. The licensee's Assessment and Reassessment policy dated June 24, 2024, indicated ongoing resident reassessment must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
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,	01640			

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NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 47 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 licensee failed to ensure all services required by the service plan were implemented and provided for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on October 15, 2020, and received assisted living services. R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with the following services: - assistance with dressing; 1 hour per day; - assistance with haircare; 1 hour per day; - assistance with grooming; 1 hour per day; - assistance with toileting; 1 hour per day; - assistance with bathing; 30 minutes per day; - medication reminders, verbal and visual; 1 hour per day; - treatment and exercises, verbal and visual; 1 hour per day;	01640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 48 - medication administration; 1 hour per day; - hands-on assistance with transfers and mobility; 30 minutes per day; - personal laundry 30 minutes; 3 times a week; - housekeeping and linen change; 1 hour per day; and - I am ok check service; 4 times per day. R1's service documentation entitled Charting View 14 Days dated February 12, 2025, through February 25, 2025, indicated the following services: - assistance in making appointments; - room cleaning; - verbally or visually remind to take all prescribed medication; - laundry; - meals/beverages; - transportation medical and non-medical; - shopping; - snacks/beverages; - socialization/ recreation; and - therapeutic exercises. R1's service documentation charting did not include the following services required by the service plan: - assistance with dressing; 1 hour per day; - assistance with haircare; 1 hour per day; - assistance with grooming; 1 hour per day; - assistance with toileting; 1 hour per day; - assistance with bathing; 30 minutes per day; - hands-on assistance with transfers and mobility 30 minutes per day; and - I am ok check service; 4 times per day. R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services.	01640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 49 R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with the following services: - assistance with dressing; 2 hours per day; - assistance with self-feeding; 1 hour per day; - assistance with grooming; 1 hour per day; - assistance with toileting; 1 hour per day; - assistance with bathing; 30 minutes per day; - medication reminders; 1 hour per day; - treatment and exercises, verbal and visual; 1 hour per day; - medication administration; 1 hour per day; - hands-on assistance with transfers and mobility; 30 minutes per day; - treatments /therapies; 2 hours per day; - eating assistance; 1 hour per day; - housekeeping and linen change; 1 hour per day; and - socialization; 5 hours per day. R2's service documentation entitled Charting View 14 Days dated February 19, 2025, through March 4, 2025, indicated the following services: - assistance in making appointments; - room cleaning; - verbally or visually remind to take all prescribed medication; - laundry; - meals/beverages; - transportation medical and non medical; - shopping; - snacks/beverages; - socialization/ recreation; and - therapeutic exercises. R2's service documentation charting did not include the following services required by the service plan: - assistance with dressing; 1 hour per day; - assistance with grooming; 1 hour per day;	01640			

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01640	Continued From page 50 - assistance with toileting; 1 hour per day; - assistance with bathing; 30 minutes per day; and - hands-on assistance with transfers and mobility; 30 minutes per day. R3 R3 was admitted to the licensee on September 12, 2023, and received assisted living services. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with the following services: - assistance with dressing; 30 minutes per day; - assistance with grooming; 30 minutes per day; - assistance with bathing; 30 minutes per day; - medication reminders, verbal; 1 hour per day; - treatment and exercises, verbal and visual; 1 hour per day; - medication administration; 1 hour per day; - housekeeping and linen change; 5 hour per day; and - socialization; 3 hours per day. R3's service documentation entitled Charting View 14 Days dated February 19, 2025, through March 4, 2025, indicated the following services: - assistance in making appointments; - self medication; - room cleaning; - dressing, grooming, bathing, continence care, positioning, eating, walking, wheeling, transferring, - assistance with ADLs; - verbally or visually remind to take all prescribed medication; - laundry; - meals/beverages; - transportation medical and non-medical;	01640			

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01640	Continued From page 51 - shopping; - snacks/beverages; - socialization/ recreation; and - therapeutic exercises. R3's service documentation charting did not include the following services required by the service plan: - assistance with continence care, positioning, walking, wheeling, transferring, and self-medication. On March 4, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-C stated they did not know why the service plan did not match the service documentation. CNS-C also stated "[licensed assisted living director/registered nurse (LALD/RN)-D] did the service plan and I just did not update the computer." The licensee's Service Plan policy dated June 24, 2024, indicated the licensee would implement and provide all services required by the current service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730			

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01730	Continued From page 52 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse reconciled medication orders for three of three	01730			

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01730	Continued From page 53 residents reviewed (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on October 15, 2020, and received assisted living services. R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with dressing, haircare, grooming, toileting, bathing, medication reminders, treatment and exercises reminders, medication administration, hands-on assistance with transfers and mobility, personal laundry, housekeeping and linen change, and I am ok check service. R1's medication administration record (MAR) for the month of February 2025, indicated R1 was taking the following medications: - alfuzosin 10 milligram (mg) tablet (tab), take 1 tab once daily; - aspirin 81mg tab, 1 tab daily; - calcium carbonate 400-500mg tab, take 1 tab daily; - Certavite 1tab daily; - clobesatol propionate 0.05%, apply topically once daily; - esomeprazole magnesium 1 capsule (cap) 20mg, take 1 cap daily; - gabapentin 100mg cap, take 1 cap at	01730			

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01730	Continued From page 54 bedtime; - stiol respimat 2.5 microgram (mcg) inhaler, inhale 2 puffs daily; - triamcinolone 0.5% cream 15gram apply topically to affected area three times daily; - acetaminophen 1 tab 500mg take 1 tab every 4 hours for pain or fever as needed (PRN); - albuterol sulfate take 2 puffs twice a day PRN; and - carboxymethylcellulose sodium 0.5%, instill 1 drop into eye as needed twice daily PRN. R1's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 1, 2024. The form indicated R1 was taking the following medications: - albuterol sulfate inhale 2 puffs four times daily; - aspirin 81mg 1 tab once daily; - atorvastatin calcium 80mg 1 tab once daily; - esomeprazole 20mg 1 cap daily; - calcium carb-cholecalciferol 500-400 mg 1 tab once daily; - Certavite 1 tab daily; and - carboxymethylcellulose 0.5% ophthalmic four times daily PRN. MEDICATIONS LISTED ON R1's PHYSICIAN ORDER DATED SEPTEMBER 1, 2024, BUT OMITTED FROM R1's MAR: - atorvastatin calcium 80mg 1 tab once daily. MEDICATIONS LISTED ON R1's MAR BUT NOT ON R1's PHYSICIAN ORDER DATED SEPTEMBER 1, 2024: - alfuzosin 10mg tab, take 1 tab once daily; - gabapentin 100mg cap, take 1 cap at bedtime;	01730			

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01730	Continued From page 55 - stiol respimat 2.5 mcg inhaler, inhale 2 puffs daily; - triamcinolone 0.5% cream 15gram apply topically to affected area three times daily; - acetaminophen 1tab 500mg take 1 tab every 4 hours for pain or fever PRN; and - clobesatol propionate 0.05%, apply topically once daily. R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's diagnosis included chronic kidney failure, kidney transplant. R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with dressing, grooming, toileting, bathing, medication reminders, medication administration, and hands-on assistance with transfers, and mobility. R2's MAR for the month of February 2025, indicated R2 was taking the following medications: - amlodipine (Norvasc) 10mg, take one tab daily; - aspirin 81mg tab, take one tab daily; - atorvastatin 20mg tab, take 1 tab daily; - carvedilol (Coreg) 6.25mg tab, take 1 tab twice daily; - CellCept (mycophenolate mofetil) 250mg tab, take 3 tabs every 12 hours; - hydralazine 25mg tab, take 1 tab twice daily; - hydrochlorothiazide 12.5mg cap, take 1 cap daily; - losartan 50mg tab, 1 tab daily; - magnesium 64mg tab, take 2 tabs every morning and 1 tab each evening; - metformin 500mg tab, take 4 tablets with	01730			

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01730	Continued From page 56 evening meals; - Pepcid (famotidine) 20mg tab, take 1 tab by mouth at bedtime; - potassium chloride 20 milliequivalent (mEq) tab, take 1 tab twice daily; - prednisone 5mg tab, taper as directed 4/15-5/20 (1.5 tab) 7.5mg, 5/20 (1 tab) 5mg; - Prograf 4 mg cap, take 2 cap every morning and take 6 cap every evening; - vitamin D (cholecalciferol) 1000 unit, take 2 tabs (2000mg) daily; - Colace 100mg cap take 1 cap every 12hours PRN; - Senokot 25mg tab, take 2 tabs at bedtime PRN; and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3. R2's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home health Certification and Plan of Care dated September 19, 2023. The form indicated R2 was taking the following medications: - CellCept 250mg cap take three tab by mouth every 12 hours; - Envarsus XR 4 mg tab, take four tabs by mouth daily; - prednisone 5mg tab PRN; - aspirin 81mg tab take 1 tab by mouth daily; - Bactrim 400-80mg tab take 1 tab by mouth daily; - Valcyte 450mg tablet take 2 tablets by mouth daily; - Pepcid 20mg tab, take 1 tab by mouth at bedtime; - Colace 100mg take 1 cap by mouth every twelve hours; - Senokot 8.5mg tab take 2 tabs by mouth daily;	01730			

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01730	Continued From page 57 - Coreg 25mg tab take 2 tabs by mouth twice daily; - Norvasc 10mg tab take 1 tab by mouth daily; - hydralazine 50mg tab take two tabs by mouth twice daily; and - K-phos-neutral 250mg tab take 4 tabs by mouth twice daily. R2's MyChart (electronic system offered to patients that provide secure online access to portions of their medical records) document dated February 24, 2025, with a list of medications ready for pick up and list of medication recently sent to R2: List of medications ready for pick up: - potassium chloride 20meq tab, take 2 tabs daily (on MAR, not on signed provider orders). List of medication sent to the licensee's address for R2 on February 24, 2025: - metformin 500mg extended-release tab, take 2 tabs daily with evening meal (on MAR, not on signed provider orders); - cholecalciferol 1000 units tab, take 2 tabs daily (on MAR, not on signed provider orders); - atorvastatin 20mg tab, take 1 tab at bedtime (on MAR, not on signed provider orders); - losartan 100mg tab, take 1 tab daily (on MAR, not on signed provider orders); - mycophenolate mofetil 250mg cap, take 3 caps every 12 hours; - Envarsus extended release 24 tab 4mg tab, take 2 tabs daily (on signed provider orders, not on MAR); - amlodipine 10mg tab, take 1 tab daily; - prednisone 5mg tab, take 1 tab daily (MAR indicated to taper, signed provider orders indicated PRN); - hydralazine 50mg tab, take 2 tabs daily (MAR indicated 25mg 1 tab twice daily, signed provider orders indicated 50mg twice daily);	01730			

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01730	Continued From page 58 - aspirin low dose 81 mg tab, take 1 tab daily; and - carvedilol 6.25mg tabs, take 2 tabs in the morning and 2 tabs in the evening (MAR indicated 6.25mg tab, take 1 tab twice daily, signed provider orders indicated 25mg tab take 2 tabs twice daily). List of medication for refill due soon: - cetirizine 10 mg tab, take 1 tab daily (not on MAR, not on signed provider orders); - mag 64mg tab take 2 tabs by mouth every morning and 1 tab each evening. Separate from transplant medication by 2 hours (on MAR, not on signed provider orders); and - famotidine 20mg, take 1 tab twice daily (MAR and signed provider orders indicated 20mg tab, take 1 tab by mouth at bedtime). MEDICATIONS LISTED ON R2's MAR BUT NOT ON R2's PHYSICIAN ORDER OR R2's MYCHART DOCUMENTS: - hydrochlorothiazide 12.5mg cap, take 1 cap daily; and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3. R3 R3 admitted to the licensee on September 12, 2023, and began receiving assisted living services. R3's diagnosis included depressive disorder and alcohol use. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, housekeeping, linen change, and socialization.	01730			

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01730	Continued From page 59 R3's MAR for the month of March 2025, indicated R3 was taking the following medications: - hydroxyzine pamoate 25mg cap, take 1 cap 3 times a day PRN; - naltrexone 50mg tab, take 1 tab once a day; - prazosin 1mg tab take 2 tabs at bedtime once daily; - sertraline 50mg tab, take 1 tab once daily; - trazadone 50mg take 1-3 tab at bedtime once daily; and - ibuprofen 400mg tab, take 1 tab PRN for pain. R3's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 12, 2023. The form indicated R3 was taking the following medications: - sertraline 50mg tab, one tab daily with food; - naltrexone 50mg tab, one tab daily; - ibuprofen 600mg tab as needed (no other direction) (signed order indicated a dose different than the MAR); - trazadone 50mg one to two tab (no other direction) (signed order indicated a dose different than the MAR); - folic acid 1000 mcg tab one daily (not on MAR); - vitamin B1 100mg tab, 1 daily (not on MAR); and - Tab-A-Vite tab, 1 daily (not on MAR). R3's unsigned after visit summary (AVS) dated January 13, 2025, indicated the following medications were current as of January 13, 2025: - acetaminophen 325mg, take one to two tab every 4 hours PRN for mild pain; - folic acid 1mg, take one tablet daily; - gabapentin 300mg cap, take one cap twice	01730			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
(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
01730	Continued From page 60 daily; - hydroxyzine pamoate 25mg cap, take 1 cap by mouth up to 3 times daily as PRN; - ibuprofen 400mg tab, take one tab four times daily PRN; - naltrexone 50mg tab, take 1 tab 50 mg daily; - nicotine 7mg/24hr patch, (no further order detail was listed on the AVS); - prazosin 1mg cap, take 2 caps at bedtime; - sertraline 50mg tab, take 1 tab daily; and - trazadone 50mg tab, take 1 tab at bedtime PRN. MEDICATIONS LISTED ON JANUARY 13, 2025, AVS AS CURRENT BUT NOT ON R3's MAR: - acetaminophen 325mg, take one to two tab every 4 hours PRN for mild pain (not on MAR, not on signed provider orders); - gabapentin 300mg cap, take one cap twice daily (not on MAR, not on signed provider orders); - hydroxyzine pamoate 25mg cap, take 1 cap by mouth up to 3 times daily as PRN (on MAR, not on signed provider orders); and - nicotine 7mg/24hr patch (not on MAR, not on signed provider orders); On March 4, 2025, at 1:17 p.m., clinical nurse supervisor (CNS)-C stated they were aware that there were a couple of medications that were not updated based on physician orders. The unlicensed personnel (ULP) were supposed to follow labels on the medication bottles. CNS-C further stated the medication labels were more reliable than the MAR as the doctors' orders changed frequently. On March 4, 2025, at 2:12 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did not have discontinued orders for any of the omitted	01730			

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01730	Continued From page 61 medications. The licensee's Medication Administration policy dated June 24, 2024, indicated a licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific medication administration instructions for each resident were documented in the resident's record for two of three residents (R3, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750			

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01750	Continued From page 62 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3 admitted to the licensee on September 12, 2023, and began receiving assisted living services. R3's diagnosis included depressive disorder and alcohol use. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, housekeeping, linen change, and socialization. R3's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 12, 2023. The form indicated R3 was taking the following medications: - sertraline 50milligram (mg) tablet (tab), 1 tab daily with food; - naltrexone 50mg tab, 1 tab daily; - ibuprofen 600mg tab, as needed (no other direction); - trazadone 50mg 1 to 2 tabs (no other direction); - folic acid 1000 microgram (mcg) tab, 1 daily; - vitamin B1 100mg tab, 1 daily; and - Tab-A-Vite tab, 1 daily.	01750			

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01750	Continued From page 63 R3's unsigned after visit summary (AVS) dated January 13, 2025, indicated the following medications were current as of January 13, 2025: - acetaminophen 325mg, take 1 to 2 tabs every 4 hours as needed (PRN) for mild pain; - folic acid 1mg, take 1 tablet daily; - gabapentin 300mg capsule (cap), take 1 cap twice daily; - hydroxyzine pamoate 25mg cap, take 1 cap by mouth up to 3 times daily as PRN; - ibuprofen 400mg tab, take 1 tab 4 times daily PRN; - naltrexone 50mg tab, take 1 tab 50 mg daily; - nicotine 7mg/24hr patch, (no further order detail was listed on the AVS); - prazosin 1mg cap, take 2 caps at bedtime; - sertraline 50mg tab, take 1 tab daily; and - trazadone 50mg tab, take 1 tab at bedtime PRN. R3's medication administration record (MAR) for the month of March 2025, indicated R3 was taking the following medications: - hydroxyzine pamoate 25mg cap, take 1 cap 3 times a day as needed "see drug leaflet" (no signed provider order in R3's record); - naltrexone 50mg tab, take 1 tab once a day "see drug leaflet"; - prazosin 1mg tab take 2 tabs at bedtime once daily "see drug leaflet" (no signed provider order in R3's record); - sertraline 50mg tab, take 1 tab once daily "see drug leaflet" (no instructions provided to administer with food per the signed provider order); - trazadone 50mg take 1 to 3 tabs at bedtime once daily "see drug leaflet" (MAR dosage differed from signed provider order); and - ibuprofen 400mg tab, take 1 tab PRN for pain "see drug leaflet" (MAR dosage differed from	01750			

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01750	Continued From page 64 signed provider order, and no instructions on parameter for how frequent medication could be administered). On March 4, 2025, 7:54 a.m., the surveyor observed unlicensed personnel (ULP)-E administer morning medication to R3. ULP-E opened the medication cabinet and took three bottles of medication out of a plastic bag and brought them to the dining room table where they had their computer. The label on the bottles read: - sertraline 50mg tab take 1 tablet by mouth daily; - naltrexone 50mg take 1 tablet by mouth daily; and - hydroxyzine pamoate 25mg Take 1 cap by mouth up to 3 times daily as needed for anxiety. ULP-E opened the hydroxyzine bottle and took two caps of hydroxyzine and put it in a medicine cup and administered it to R3 along with sertraline one tab and naltrexone one tab. The surveyor inquired about the hydroxyzine dosage as the order on the MAR indicated to take one cap three times a day as needed. ULP-E stated R3 took the hydroxyzine every morning. ULP-E stated they could give one to two caps of hydroxyzine per the label on the bottle. The surveyor observed the label read "hydroxyzine pamoate 25mg Take one cap by mouth up to three times daily as needed for anxiety". ULP-E stated hydroxyzine was for R3's anxiety, the doctor told them to give R3 two caps in the morning, and R3 gets anxious and fidgety if R3 does not get the hydroxyzine in the morning. ULP-E further stated the nurse also told them to give two caps of hydroxyzine every morning. On March 4, 2025, at 1:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated R3's doctor told them R3 could get two	01750			

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01750	Continued From page 65 tablets of hydroxyzine. The surveyor inquired how they would know if one or two tabs were administered since it was not indicated on the MAR. LALD/RN-D stated, "We should have known to create something that is not confusing." R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's diagnosis included chronic kidney failure, kidney transplant. R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with dressing, grooming, toileting, bathing, medication reminders, medication administration, and hands-on assistance with transfers, and mobility. R2's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 19, 2023. The form indicated R2 was taking the following medications: - CellCept (mycophenolate mofetil) 250mg cap take 3 tabs by mouth every 12 hours; - envarsus XR (prograf) 4 mg tab, take 4 tabs by mouth daily; - prednisone 5mg tab as needed; - aspirin 81mg tab take 1 tab by mouth daily; - Bactrim 400-80mg tab take 1 tab by mouth daily; - Valcyte 450mg tablet take 2 tablets by mouth daily; - Pepcid (famotidine) 20mg tab, take 1 tab by mouth at bed time; - Colace 100mg take 1 cap by mouth every twelve hours; - Senokot 8.5mg tab take 2 tabs by mouth	01750			

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01750	Continued From page 66 daily; - Coreg (carvedilol) 25mg tab take 2 tabs by mouth twice daily; - Norvasc (amlodipine) 10mg tab take 1 tab by mouth daily; - hydralazine 50mg tab take 2 tabs by mouth twice daily; and - K-phos-neutral 250mg tab take 4 tabs by mouth twice daily. R2's MyChart (electronic system offered to patients that provide secure online access to portions of their medical records) document dated February 24, 2025, with a list of medications ready for pick up and list of medication recently sent to R2: List of medications ready for pick up: - potassium chloride 20 milliequivalent (mEq) tab, take 2 tabs daily. List of medication sent to the licensee's address for R2 on February 24, 2025: - metformin 500mg extended-release tab, take 2 tabs daily with evening meal; - cholecalciferol 1000 units tab, take 2 tabs daily; - atorvastatin 20mg tab, take 1 tab at bed time; - losartan 100mg tab, take 1 tab daily; - mycophenolate mofetil 250mg cap, take 3 caps every 12 hours; - envarsus extended release 24 tab 4mg tab, take 2 tabs daily; - amlodipine 10mg tab, take 1 tab daily; - prednisone 5mg tab, take 1 tab daily; - hydralazine 50mg tab, take 2 tabs daily; - aspirin low dose 81 mg tab, take 1 tab daily; and - carvedilol 6.25mg tabs, take 2 tabs in the morning and 2 tabs in the evening. List of medication for refill due soon: - cetirizine 10 mg tab, take 1 tab daily;	01750			

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01750	Continued From page 67 - mag 64mg tab take 2 tabs by mouth every morning and 1 tab each evening. Separate from transplant medication by 2 hours; and - famotidine 20mg, take 1 tab twice daily. R2's MAR for the month of February 2025, indicated R2 was taking the following medications: - amlodipine 10mg, take 1 tab daily; - aspirin 81mg tab, take 1 tab daily; - atorvastatin 20mg tab, take 1 tab daily (no signed provider order in R2's record); - carvedilol 6.25mg tab, take 1 tab twice daily (MAR dosage differed from signed provider order); - CelleCept 250mg tab, take 3 tabs every 12 hours; - hydralazine 25mg tab, take 1 tab twice daily (MAR dosage differed from signed provider order); - hydrochlorothiazide 12.5mg cap, take 1 cap daily (no signed provider order in R2's record); - losartan 50mg tab, 1 tab daily (no signed provider order in R2's record); - magnesium 64mg tab, take 2 tabs every morning and 1 tab each evening (no signed provider order in R2's record and no instruction on the MAR per R2's MyChart document to administer separate from transplant medication (prograf) by two hours); - metformin 500mg tab, take 4 tablets with evening meals (no signed provider order in R2's record); - Pepcid 20mg tab, take 1 tab by mouth at bedtime; - potassium chloride 20 mEq tab, take 1 tab twice daily (no signed provider order in R2's record); - prednisone 5mg tab, taper as directed 4/15-5/20 (1.5 tab) 7.5mg, 5/20 (1 tab) 5mg (MAR	01750			

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01750	Continued From page 68 dosage/directions differed from signed provider order); and - Prograf 4 mg cap, take 2 caps every morning and take 6 caps every evening (MAR dosage differed from signed provider order); - vitamin D 1000 unit, take 2 tabs (2000mg) daily (no signed provider order in R2's record); - Colace 100mg cap take 1 cap every 12hours PRN (directions differed from signed provider order); - Senokot 25mg tab, take 2 tabs at bedtime PRN (directions differed from signed provider order); and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3 (no signed provider order in R2's record, and no instructions on parameter for how frequent medication could be administered). On March 4, 2025, at approximately 8:10 a.m., the surveyor observed the following on R2's medication bottles: - losartan 100mg take 1 tab daily; - hydralazine 50mg, take 2 tabs twice a day; and - carvedilol 6.25mg tabs, take 2 tabs in the morning and 2 tabs in the evening. On March 4, 2025, at 8:15 a.m., the surveyor asked ULP-E to demonstrate what dosage they would administer to R2 for the above listed three medications as neither the label on the bottle, the signed physician order, the MyChart document, or the MAR matched. ULP-E stated they gave two carvedilols 6.25mg, two tabs (12.5mg) per the label on the bottle; losartan 100mg, one tab, and hydralazine 50mg, two tabs (100mg). ULP-E further stated the order on the bottle was supposed to take precedence over the MAR. ULP-E stated the medication orders changed	01750			

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01750	Continued From page 69 frequently and the nurses tried to update the system regularly, but they did not know why the MAR was not updated. On March 4, 2025, at 8:32 a.m., ULP-E stated they were trained on how to administer medication by the clinical nurse supervisor (CNS). ULP-E stated the CNS trained them to follow the bottle, "They told us to follow the label on the bottle because that is doctor's order, and doctor's order is higher." ULP-E stated the CNS-C told them the label on the bottle was the doctor's order. ULP-E further stated, "we have to follow that [referring to the label on medication bottles] unless it is open to interpretation like the hydroxyzine [R3's medication discussed above] then we follow the nurses order; like for the trazadone [R3's order listed above] where it says one to three, we do not give higher or lower we give two". On March 4, 2025, at 1:17 p.m., CNS-C stated they were aware that there were a couple of medications that were not updated based on the doctor's order. The ULPs were supposed to follow labels on the medication bottles. CNS-C further stated the medication label on the bottle was more reliable than the MAR as the doctors' orders changed frequently, therefore the ULPs got in the habit of reading labels. The licensee's Coordination in the Medication Program policy dated June 24, 2024, indicated the RN was responsible for coordinating the Medication Management Program with other health care providers, including the primary care provider and pharmacist, serving the resident. The licensee's Medication Documentation policy dated June 24, 2024, read, "1. Complete	01750			

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01750	Continued From page 70 documentation of medication administration includes the following Resident's name Medication name Medication dosage Date and time of administration Method/route of administration Signature and Title of staff administering the medication 2. If the administration of one or more medications was not completed, staff will document the following a. The reason why the medication was not administered b. Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan c. Appropriate notification to RN Supervisor or other persons as instructed regarding missed dosages d. Medication Error report, if appropriate 3. Rise Home Healthcare will document medication set up according to the following a. Date of medication setup b. Name of medication c. Quantity of dose d. Times to be administered e. Route of administration f. Name/title of person completing medication setup 4. Documentation of medication administration and medication set up will be completed promptly. 5. For PRN medications, documentation will include, when appropriate, the reason for the medication and follow-up to determine its effectiveness. 6. When medication administration is delegated	01750			

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01750	Continued From page 71 to unlicensed personnel, the clinical records and/or personnel files will contain documentation of appropriate competency, education and orientation.*" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders were accurately transcribed to the medication administration record and failed to document medication administration for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760			

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01760	Continued From page 72 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 the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on October 15, 2020, and received assisted living services. R1's signed service plan form, dated January 1, 2024, indicated R1 received assistance with dressing, haircare, grooming, toileting, bathing, medication reminders, treatment and exercises reminders, medication administration, hands-on assistance with transfers and mobility, personal laundry 30 minutes, housekeeping and linen change, and I am ok check service. R1's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 1, 2024. The form indicated R1 was taking the following medications: - albuterol sulfate inhale 2 puffs four times daily; - aspirin 81 milligrams (mg) 1 tablet (tab) once daily; - atorvastatin calcium 80mg 1 tab once daily; - esomeprazole 20mg 1 capsule (cap) daily; - calcium carb-cholecalciferol 500-400 mg 1 tab once daily; - Certavite 1 tab daily; and - carboxymethylcellulose 0.5% ophthalmic four times daily as needed (PRN).	01760			

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01760	Continued From page 73 R1's medication administration record (MAR) for the month of February 2025 indicated R1 was taking the following medications: - alfuzosin 10 mg tab, take 1 tab once daily; - aspirin 81mg tab, 1 tab daily; - calcium carbonate 400-500mg tab, take 1 tab daily; - Certavite 1tab daily; - clobesatol propionate 0.05%, apply topically once daily; - esomeprazole magnesium 1 cap 20mg, take 1 cap daily; - gabapentin 100mg cap, take 1 cap at bedtime; - stiollo respimat 2.5 micrograms (mcg) inhaler, inhale 2 puffs daily; - triamcinolone 0.5% cream 15gram apply topically to affected area three times daily; - acetaminophen 1tab 500mg take 1 tab every 4 hours for pain or fever as needed; - albuterol sulfate take 2 puffs twice a day as needed; and - carboxymethylcellulose sodium 0.5%, instill 1 drop into eye as needed twice daily as needed. R1's MAR dated February 1, through February 28, 2025, was not transcribed according to the signed provider's orders and lacked documentation on all medication administration for all shifts from February 21 through February 28, 2025. R2 R2 was admitted to the licensee on July 25, 2020, and received assisted living services. R2's diagnosis included chronic kidney failure, kidney transplant.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(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
01760	Continued From page 74 R2's signed service plan form, dated September 15, 2023, indicated R2 received assistance with dressing, grooming, toileting, bathing, medication reminders, medication administration, and hands-on assistance with transfers, and mobility. R2's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 19, 2023. The form indicated R2 was taking the following medications: - CellCept 250mg cap take 3 tab by mouth every 12 hours; - Envarsus XR 4 mg tab, take 4 tabs by mouth daily; - prednisone 5mg tab as needed; - aspirin 81mg tab take 1 tab by mouth daily; - Bactrim 400-80mg tab take 1 tab by mouth daily; - Valcyte 450mg tablet take 2 tabs by mouth daily; - Pepcid 20mg tab, take 1 tab by mouth at bedtime; - Colace 100mg take 1 cap by mouth every twelve hours; - Senokot 8.5mg tab take 2 tabs by mouth daily; - Coreg 25mg tab take 2 tabs by mouth twice daily; - Norvasc 10mg tab take 1 tab by mouth daily; - hydralazine 50mg tab take 2 tabs by mouth twice daily; and - K-phos-neutral 250mg tab take 4 tabs by mouth twice daily. R2's MAR for the month of March 2025 indicated R2 was taking the following medications: - amlodipine 10mg tab, take 1 tab daily; - aspirin 81 mg tab, take 1 tab daily;	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(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
01760	Continued From page 75 - atorvastatin 20mg tab, take 1 tab daily; - carvedilol 6.25mg tab, take 1 tab twice daily; - CellCept 250mg cap, take 3 caps every 12 hours; - hydralazine 25mg tab, take 1 tab twice daily; - hydrochlorothiazide 12.5mg cap, 1 cap daily; - losartan 50mg, take 1 tab daily; - magnesium 64mg tab, take 2 tabs every morning and 1 tab each evening; - metformin 500mg take 4 tabs with evening meal; - Pepcid 20mg tab, take 1 tab at bedtime; - potassium chloride 20mEq tab take 1 tab twice daily; - prednisone 5mg tab, taper as directed 4/15-5/20 (1.5 tab) 7.5mg, 5/20 (1 tab) 5mg; - Prograf 4 mg cap, take 2 caps every morning and take 6 caps every evening; - Vitamin D 1000 unit, take 2 tabs (2000mg) daily; - Colace 100mg cap take 1 cap every 12hours PRN; - Senokot 25mg tab, take 2 tabs at bedtime PRN; and - Tylenol 300mg tab, take by mouth according to temperature and pain level more than 3. R2's MAR dated February 1, through February 28, 2025, was not transcribed according to the signed provider's orders and lacked documentation on all medication administration for all shifts from February 22 through February 28, 2025. R3 R3 admitted to the licensee on September 12, 2023, and began receiving assisted living services. R3's diagnosis included depressive disorder and	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112		
(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
01760	Continued From page 76 alcohol use. R3's signed service plan form, dated September 15, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, housekeeping, linen change, and socialization. R3's record included a signed physician order on a Department of Health and Human services for Medicare & Medicaid form entitled Home Health Certification and Plan of Care dated September 12, 2023. The form indicated R3 was taking the following medications: - sertraline 50mg tab, 1 tab daily with food; - naltrexone 50mg tab, 1 tab daily; - ibuprofen 600mg tab as needed (no other direction); - trazadone 50mg 1 to 2 tabs, (no other direction); - folic acid 1000 mcg tab 1 daily; - Vitamin B1 100mg tab, 1 daily; and - Tab-A-Vite tab, 1 daily. R3's MAR for the month of March 2025, indicated R3 was taking the following medications: - hydroxyzine pamoate 25mg cap, take 1 cap 3 times a day as needed; - naltrexone 50mg tab, take 1 tab once a day; - prazosin 1mg tab take 2 tabs at bedtime once daily; - sertraline 50mg tab, take 1 tab once daily; - trazadone 50mg take 1-3 tab at bedtime once daily; and - ibuprofen 400mg tab, take 1 tab PRN for pain. R3's MAR dated February 1, through February 28, 2025, was not transcribed according to the signed provider's orders and lacked	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
(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
01760	Continued From page 77 documentation on all medication administration for all shifts from February 22 through February 28, 2025. On March 4, 2025, at 1:17 p.m., clinical nurse supervisor (CNS)-C stated they were aware that there were a couple of medications that were not updated based on physician orders. The unlicensed personnel (ULP) were supposed to follow labels on the medication bottles. CNS-C further stated the medication labels were more reliable than the MAR as the doctors' orders changed frequently. On March 4, 2025, at 2:12 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did not have discontinue orders for any of the omitted medications. On March 4, 2025, at 2:38 p.m., CNS-C acknowledged the lack of charting for all residents for the above-mentioned dates, and stated residents had taken their medications but the ULPs did not document. CNS-C stated they would have to talk to the ULPs regarding the lack of documentation. The licensee's Medication Documentation policy dated June 24, 2024, indicated each medication administered by the licensee staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. The licensee's Medication Orders policy dated June 24, 2024, read, "Policy Statement: Rise Home Healthcare will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted living Bill of Rights and in the Health	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER RISE HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 547 CONTINENTAL DRIVE NEW BRIGHTON, MN 55112			
(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
01760	Continued From page 78 Insurance Portability and Accountability Act. Procedure: 1. Rise Home Healthcare will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. 2. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. 3. Verbal prescription orders from an authorized prescriber will be received by a nurse or pharmacist. a. The pharmacist, LPN or RN acting on behalf of the prescriber may communicate to the pharmacy provider a prescription drug order by a practitioner authorized to prescribe drugs or devices. b. The prescription drug orders will be transmitted via facsimile or a secure electronic format to the pharmacy c. Schedule II controlled substances require an original written prescription drug order manually signed by the authorized practitioner except in an emergency i. Immediate administration of the controlled substance is necessary for the proper treatment of the intended user ii. No appropriate alternative treatment is available iii. It is not reasonably possible for the prescribing practitioner to provide a written prescription drug order to the pharmacy. 4. When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. 5. All prescriptions and orders received by Rise Home Healthcare either verbally, in writing or electronically will be kept confidential. 6. When staff become aware of any medications	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
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01760	Continued From page 79 or dietary supplements being used by a resident that are not included in the assessment, the information will be documented, and the RN will be notified. 7. Rise Home Healthcare has determined not to require a prescription for over-the- counter medications and dietary supplements. These medications will be included on the Medication Profile annually renewed by the physician." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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Food and Beverage Establishment Inspection Report

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Location:

Rise Home Health Care
547 Continental Drive
New Brighton, MN 55112
Ramsey County, 62

Establishment Info:

ID #: 0037864
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122075920
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

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

NO ILLNESS LOG IN USE. ADVISED STAFF TO RECORD EMPLOYEES WHO CALL IN OR GO HOME SICK. LOG PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

7-200 Toxic Supplies and Applications

7-204.11

**** Priority 1 ****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

FACILITY USES CHLORINE FOR SANITIZER. SANI SPRAY BOTTLE MEASURED +200 PPM. ADVISED STAFF TO MAINTAIN CONCENTRATION BETWEEN 50-100 PPM. CORRECTED ON SITE TO 100 PPM. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

2-500 Responding to contamination events

2-501.11

**** Priority 2 ****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

NO CLEAN UP PROCEDURES OR KIT AVAILABLE. ADVISED STAFF TO PROVIDE AT LEAST

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ONE OPTION AND TRAIN ALL EMPLOYEES. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO THERMOMETER AVAILABLE ON SITE. ADVISED STAFF TO PROVIDE A THIN PROBE THERMOMETER TO MEASURE INTERNAL TEMPERATURES OF FOOD. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO TEST KIT AVAILABLE ON SITE. ADVISED STAFF TO PROVIDE AND MAINTAIN AN IRREVERSIBLE THERMOMETER OR THERMOLABELS TO MEASURE UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

FACILITY USES CHLORINE. NO TEST KIT AVAILABLE. ADVISED STAFF TO PROVIDE AND MAINTAIN (REFER TO EXPIRATION DATE). COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

7-100 Toxic Labeling

7-102.11 **** Priority 2 ****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SANI SPRAY BOTTLE OBSERVED UNLABELED. ADVISED STAFF TO PROVIDE AND MAINTAIN LABEL. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

2-100 Supervision

2-102.12AMN

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

REPEAT FROM 7/5/22. NO CFPM EMPLOYED, ONLY COURSE CERTIFICATE IS AVAILABLE. ADVISED STAFF TO RE-TAKE THE EXAM AND SEND CERTIFICATE TO THE STATE WITHIN 6 MONTHS OF PASSING. INFO PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

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4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

FACILITY USES WOODEN CUTTING BOARDS - ONE IS A UNDER COUNTER PULL OUT UNDERNEATH THE MICROWAVE. ADVISED STAFF TO PROVIDE A CUTTING BOARD THAT IS NOT MADE OF AN ABSORBENT MATERIAL (EX: PLASTIC, ETC). COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

PER STAFF, LEFTOVER FOOD MADE IN HOUSE IS KEPT FOR ADDITIONAL DAYS. ADVISED STAFF TO DISCONTINUE PRACTICE AND DISCARD LEFTOVERS BY END OF DAY. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

KITCHEN FRIDGE DOES NOT HAVE A DIGITAL TEMPERATURE READING AND NO THERMOMETER WAS OBSERVED WITHIN UNIT. ADVISED STAFF TO PROVIDE. PLACE THERMOMETER AT FRONT OF TOP SHELF. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

4-500 Equipment Maintenance and Operation

4-501.11AB

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

PER STAFF, DISH MACHINE IS NOT WORKING AND IS IN NEED OF REPAIR/REPLACEMENT. ADVISED STAFF TO WASH DISHWARE USING 3 COMPARTMENT SET UP UNTIL UNIT IS REPAIR/REPLACED. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

PACK OF SINGLE USE PLATES STORED ON FLOOR OF OUTDOOR DECK. ADVISED STAFF TO RELOCATE ITEMS INSIDE AND AT LEAST 6 INCHES OFF THE FLOOR. CORRECTED ON SITE.

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COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

BATHROOM MISSING HANDWASHING SIGN REMINDER. ADVISED STAFF TO POST. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

DRAWER TO RIGHT SIDE OF STOVE OBSERVED TO BE MISSING THE COVER AND EXPOSES UNSEALED WOOD. ADVISED STAFF TO REINSTALL COVER. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

Surface and Equipment Sanitizers

Chlorine: = +200 PP at Degrees Fahrenheit

Location: SANI SPRAY BOTTLE

Violation Issued: Yes

Chlorine: = 100 PPM at Degrees Fahrenheit

Location: SANI SPRAY BOTTLE*

Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK 1

Temperature: 40 Degrees Fahrenheit - Location: FRIDGE

Violation Issued: No

Process/Item: MILK 2

Temperature: 40 Degrees Fahrenheit - Location: FRIDGE

Violation Issued: No

Process/Item: BUTTER

Temperature: 40 Degrees Fahrenheit - Location: FRIDGE

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	5	8

Inspection was completed with Dee Mosissa as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Items on the report were discussed with Hawa Hersi and other present employees.

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Discussed highly susceptible populations, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day.

This facility has a residential kitchen with residential equipment, wooden cabinetry, and linoleum flooring.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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

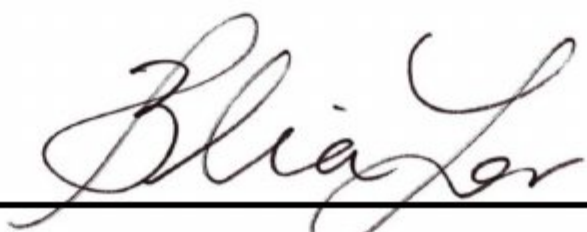
I acknowledge receipt of the Minnesota Department of Health inspection report
number 1043251067 of 03/03/25.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Signed: _____

Hawa Hersi
PIC

Signed:  _____

Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us