Electronically Delivered

January 6, 2025

Licensee
Our House
1017 7th Street Northwest
Faribault, MN 55021

RE: Project Number(s) SL20095015

Dear Licensee:

On November 25, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 4, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 9, 2024

Licensee
Rizon Homes
1017 7th Street Northwest
Faribault, MN 55021

RE: Project Number(s) SL20095015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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 $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20095	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIZON HOMES	1017 7TH STREET NW FARIBAULT, MN 55021

(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: SL20095015 On September 3, 2024, through September 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were eight residents; eight receiving services under the Assisted Living license. An immediate correction order was identified on September 3, 2024, issued for SL20095015-0, tag identification 0820. On September 3, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G. An immediate correction order was identified on September 4, 2024, issued for SL20095015-0,	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.	

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0 000	Continued From page 1 tag identification 1290 at a level 3, widespread (l)..	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of	0 250		

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0 250	Continued From page 2 the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and 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: During entrance conference on September 3,	0 250		

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0 250	Continued From page 3 2024, at 10:00 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she was aware of the Assisted living regulations and requirements. The licensee failed to ensure the following policies and procedures were developed and kept current: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance. - orientation to and implementation of the assisted living bill of rights. - ensuring that nurses and licensed health professionals have current and valid licenses to practice. - 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. On September 4, 2024, at 9:30 a.m., CNS/LALD-A stated they did not have all of the required policies, and there were no policies other than what was in the policy manual. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 4 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 3, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 5 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment. 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 September 3, 2024, at 10:20 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A provided a copy of their TB risk assessment and stated the TB risk assessment was last completed March 2023, and had made a note to complete again in March 2025. CNS/LALD-A was unaware TB risk assessments	0 660		

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0 660	Continued From page 6 was required to be completed annually. The licensee's TB and Communicable Diseases policy last updated January 25, 2024, indicated the facility tuberculosis risk assessment worksheet for health care settings will be filled out every two years. The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2023, indicated: Settings should perform a facility risk assessment on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680		

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0 680	Continued From page 7 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 have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of 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, 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 Disaster plan dated March 19, 2024, was reviewed and lacked the following: - Procedures for tracking of staff and patients - Policies and procedures for volunteers - Roles under a waiver declared by secretary. On September 4, 2024, at 1:54 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A reviewed the disaster plan with the surveyor and stated the information listed above	0 680		

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0 680	Continued From page 8 was missing. The licensee's Emergency Response Reporting and Review Policy dated March 25, 2024, indicated an emergency response plan must be readily available to staff and persons receiving services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in	0 780		

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0 780	Continued From page 9 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 September 3, 2024, at 11:20 a.m., survey staff toured the facility with director of maintenance (DM)-B. During the tour, the surveyor observed smoke alarms were not installed outside bedrooms 3 and 7. The header heights where doors had been removed measured 27 inches outside bedroom 3 and 24 inches outside bedroom 7. During the facility tour interview on September 3, 2024, DM-B verified the smoke alarm installation locations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 790	Continued From page 10	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition 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 of the residents). The findings include: On September 3, 2024, at 11:20 a.m., survey staff toured the facility with director of maintenance (DM)-B. During the tour, the	0 790		

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0 790	Continued From page 11 surveyor observed monthly inspections had not been recorded on the back of the annual maintenance tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview on September 3, 2024, DM-B verified monthly portable fire extinguisher inspections had not been completed while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20095	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIZON HOMES	1017 7TH STREET NW FARIBAULT, MN 55021

(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
0 800	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 3, 2024, at 11:20 a.m., survey staff toured the facility with director of maintenance (DM)-B. During the tour, the surveyor observed the following: 1. The ramp installed on the exterior of the building obstructed the egress windows in occupied resident bedrooms 3 and 4. This improper ramp placement could delay exiting in the event of an emergency. 2. The carpet was soiled in occupied resident bedrooms 6, 8, 9, and 10. 3. Several floor tiles were cracked and missing in the resident dining room. 4. There were two holes in the wall at the top of the basement stairs. 5. In the sitting room closet on the upper floor, the interior surfaces were in disrepair and one wall was not finished. During the facility tour interview on September 3, 2024, DM-B verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 13 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content and	0 810		

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0 810	Continued From page 14 provide required training. 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 September 3, 2024, housing manager (HM)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP escape floor plan inappropriately labeled bathroom, kitchen, laundry room, and sitting room windows as exits. During an interview on September 3, 2024, at 2:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A verified these windows should not be labeled as exits and stated the floor plan would be revised. TRAINING Record review indicated that the licensee failed to provide training to employees on the FSEP upon hire evident by the lack of training documentation to support this had been completed. A FSEP training record for a new hire employee was provided but the employee had not signed the record. During an interview on September 3, 2024, at 2:30 p.m., CNS/LALD-A stated the FSEP training had not been documented correctly and	0 810		

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0 810	Continued From page 15 explained employees were trained on the facility FSEP at the time of hire and then twice a year, in April and October. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect one resident and all 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 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	0 820	This immediate correction order identified on September 3, 2024, has had the immediacy lifted as of September 3, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 16 situation has occurred only occasionally). The findings include: On September 3, 2024, at 11:20 a.m., survey staff toured the facility with director of maintenance (DM)-B. The egress windows in resident bedrooms were opened by DM-B and measured by the surveyor. The noncompliant egress window measurements were as follows: Resident occupied bedroom 8 - the two windows both measured 19 inches open width, 31 inches open height, and 589 square inches open area. The egress windows in bedroom 8 did not meet the minimum requirements for safe egress. Egress windows in existing sleeping rooms must have a minimum open width of 20 inches and minimum open height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. During the facility tour interview on September 3, 2024, DM-B verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to obtain a building permit and submit a Minnesota Department of Health engineering plan review application for installation of a new ramp.	0 830		

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0 830	Continued From page 17 This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 3, 2024, at 11:20 a.m., survey staff toured the facility with director of maintenance (DM)-B. During the tour, the surveyor observed a ramp was installed on the back of the building. During the facility tour interview on September 3, 2024, DM-B stated the ramp had been installed a few months ago and the city did not require a permit because the ramp was not attached to the building. DM-B stated the licensee did not know the Minnesota Department of Health required a permit and plan review for the new ramp installation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290		

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01290	Continued From page 18 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one unlicensed personnel (ULP-D). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order on September 4, 2024. This practice resulted in a level three violation (a violation that harmed a client/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 the potential to affect a large portion or all the residents). The findings include: ULP-D was hired on June 28, 2024, to provide direct care services to the licensee's residents. On September 3, 2024, at 12:15 p.m. ULP-D was observed entering R2's room to administer	01290		

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01290	Continued From page 19 afternoon insulin. R2 indicated his blood sugar was low. ULP-D left the room and informed licensed practical nurse (LPN)-E of the low blood sugar and was directed to give R2 orange juice and recheck the blood sugar later. On September 4, 2024, at 8:30 a.m. the surveyor observed ULP-D administer medications independently to R2 and R3. ULP-D's employee record contained a background study, submitted by a separate location operated by the same corporation dated June 21, 2024. ULP-D's employee record lacked evidence of a cleared background study affiliated with the licensee. On September 3, 2024, at 3:00 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had trouble previously with background studies and were switching over the sensitive information person (SIP). CNS/LALD-A stated the current SIP was told they had to do a new background check on each employee, and they were not sure that was done. On September 4, 2024, at 8:30 a.m. CNS/LALD-A provided the surveyor with a copy of the NETStudy 2.0 report affiliated with the licensee (20095). The report indicated that ULP-D was affiliated on September 3, 2024, after the survey was started. The report included two other employees: the owner completed on April 15, 2022, and CNS/LALD-A completed on April 18, 2022. On September 4, 2024, at 9:16 a.m. the licensee's background check policy was requested. Housing manager (HM)-C reviewed the policy manual with the surveyor and was not	01290		

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01290	Continued From page 20 able find a policy. CNS/LALD-A stated they did not have any policies other than what was in the policy manual. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the disposition of medications including the medication's prescription number for one of one discharged resident (R1).	01910		

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01910	Continued From page 21 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: R1 was discharged to another facility on February 1, 2024. R1's record included a discharge medication verification form that included medication name, strength, and amount, but failed to include the prescription number as required. On September 3, 2024, at 1:17 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she was aware of the requirement but did not realize it was needed if a resident was being discharged to another facility. The licensee's Medication Administration policy dated November 18, 2021, indicated medication disposal but failed to identify the proper use of recording medication that will be destroyed or given to resident upon discharge. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 22 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 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 treatment or therapy management plan to include all required content for one of one resident (R2) who had treatments managed by the facility.	01940		

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01940	Continued From page 23 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 3, 2024, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided treatment and therapy services to residents as prescribed. R2 started receiving services on May 7, 2022, with a diagnosis of diabetes, depression, and anxiety. On September 3, 2024, at 12:15 p.m. unlicensed personnel (ULP)-D was observed reviewing the medical record for R2 and gathered a medication box to administer R2's afternoon insulin. R2 stated his blood sugar was 71 and did not want insulin. R2's service plan dated May 10, 2024, indicated R2 needed verbal or visual medication reminders and assistance with insulin injections. The service plan also indicated the Dexcom and transmitter (continuous blood glucose monitoring system) were changed by the ULP. On September 3, 2024, at 11:50 a.m. CNS/LALD-A stated R2's file did not have a treatment plan and she was not aware one was	01940		

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01940	Continued From page 24 needed for R2's Dexcom. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza, # 2105
Mankato, MN

Type: Full
Date: *09/03/24*
Time: 12:25:55
Report: 1028241042

Food and Beverage Establishment Inspection Report

Location:
Our House
1017 7th Street NW
Faribault, MN55021
Rice County, 66

Establishment Info:
ID #: 0008742
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Rison Homes Minnesota Inc.

Phone #: 5073346853
ID #: 55244

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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
Employ a Certified Food Protection Manager. Lexi Lacanne from this establishment is scheduled to take a class.

Comply By: 09/03/24

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
The container holding sugar in the kitchen area must be labeled.
Corrected on Site

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
The damaged floor surface under the refrigerator in the kitchen area must be repaired to remove rust build-up.

Comply By: 10/03/24

Food and Equipment Temperatures

Type: Full
Date: *09/03/24*
Time: 12:25:55
Report: 1028241042
Our House

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

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 1028241042 of 09/03/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Nina McKinstrey
House Supervisor

Signed: Ryan Miller
Ryan Miller
Public Health Sanitarian III
Mankato
507-995-7672
Ryan.Miller@state.mn.us