DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 21, 2025

Licensee
Rise Up Home Care LLC
7207 France Avenue
Brooklyn Center, MN 55429

RE: Project Number(s) SL39173016

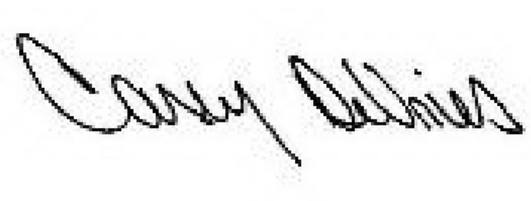
Dear Licensee:

On June 6, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 4, 2025. 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,



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

JMD

Electronically Delivered

May 7, 2025

Licensee
Rise Up Home Care LLC
7207 France Avenue
Brooklyn Center, MN 55429

RE: Project Number(s) SL39173016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 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:

St - 0 - 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: 651-201-3789
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39173	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISE UP HOME CARE LLC	7207 FRANCE AVENUE BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL39173016-0 On March 31, 2025, through April 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four (4) residents, all whom received services under the Assisted Living Facility license. On April 1, 2025, an immediate correction order for tag identification number 1290 was issued. During the course of the survey, the licensee took action to mitigate the risk. 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.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license effective July 12, 2024, with an expiration date of July 11, 2025. EMPLOYEE START DATE AND RECORDS On March 31, 2025, at 10:17 a.m., the surveyor arrived at the licensee's facility (a residential-style home) to initiate a survey. Upon arrival, the surveyor observed unlicensed personnel (ULP)-B on the phone regarding one of the residents. ULP-B was alone overseeing four residents, and	0 330		

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0 330	Continued From page 2 the surveyor observed her between 10:20 a.m. to 2:10 p.m., cleaning a bathroom, sweeping, and washing dishes, provide snacks to two residents, provide smoking supervision to one resident, check blood glucose, administer insulin for two residents, and overall supervision of all residents. During that time period, ULP-B assisted the surveyor by providing requested documents. The licensee's Staff List dated March 31, (year was cut off), read ULP-B's hire date was December 16, 2024. During interview at 11:12 a.m. and 11:49 a.m., ULP-B stated she was new and had worked for a few days and was hired to work full-time. ULP-B would not give the surveyor an approximate date when she was hired nor exactly how many days she worked on her own since training. At 12:00 p.m., licensed assisted living director/owner (LALD/O)-D arrived at facility and began the entrance conference. During interview at 12:36 p.m., LALD/O-D stated ULP-B was still in training, when the surveyor mentioned ULP-B was working on her own, LALD/O-D stated she was always at the facility as the second person. At 1:00 p.m., CNS-A arrived at facility, and at 1:05 p.m., completed the entrance conference with the surveyor. At 1:45 p.m., the surveyor and CNS-A were in the downstairs office when licensed assisted living director/owner (LALD/O)-D opened the door and stated insulin administration was ready to be given and said because ULP-B was not done with training, she needed CNS-A to come upstairs to	0 330		

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0 330	Continued From page 3 assist. CNS-A told LALD/O-D that ULP-B was already trained, and everyone went upstairs to observe ULP-B check blood glucose and administer insulin to R2 and R3. At 2:49 p.m., the surveyor requested LALD/O-D to provide ULP-B's employee file, LALD/O-D stated, "let me check with [CNS-A]." At 2:55 p.m., LALD/O-D explained ULP-B was hired in December, completed her training, but did not start working with the residents until recently because there were no open shifts. On April 1, 2025, at 9:40 a.m., the surveyor received ULP-B's employee file and LALD/O-D explained the competencies were completed around first week in March but ULP-B started working last week. ULP-B's competency records dated March 6-8, 2025, indicated CNS-A deemed ULP-B competent on following skills such as personal cares, hand hygiene, client mobility, range of motion, medication administration, and blood glucose monitoring. At 1:04 p.m., during record review with CNS-A, the surveyor noted discrepancies with ULP-B's start date as the surveyor observed ULP-B's name documented for medication set up for a leave of absence in December 2024. The surveyor asked CNS-A for clarification on the discrepancy and CNS-A was unable to explain and stated ULP-B's above competencies were created upon surveyor request. CNS-A explained ULP-B was trained and competent on all the required tasks but failed to document it. FACILITY RECORDS	0 330		

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0 330	Continued From page 4 Throughout the survey, the licensee provided facility records bearing names of another licensee that were not affiliated to current licensee. The following records were provided during the survey: -Fire Safety, Evacuation and Fire Drills Plan effective August 1, 2022, indicated evacuation procedures were to meet at the end of the driveway on "O' Henry Road" which did not exist in the immediate area. -undated [another licensee name] Hazard Vulnerability Assessment was provided as the licensee's assessment; -Memorandum of Understanding between licensee and another licensee was unsigned and included a third licensee's name that was not supposed to be there; -[Licensee] Alzheimer's Disease-Notice of Services indicated another licensee's name in the introduction of the program; and -Quality Management Committee Meeting dated January 24, 2024, and October 25, 2024, had another licensee's name on the header of the document and were both on infection control. Both documents included the exact same performance data review, action plan, staff training update, resident communication, and next steps. During the entrance conference on March 31, 2025, at 12:13 p.m., LALD/O-D stated they completed quarterly quality meetings and last one completed was in December 2024. On April 2, 2025, at 12:03 p.m., the surveyor asked LALD/O-D about the notice of dementia training and quality meetings bearing names of different licensee's, she explained that a group of licensees had access to multiple templates they can choose from and modify it to make it their	0 330		

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0 330	Continued From page 5 own. LALD/O-D stated she would need to change the names so they were no longer on the forms. Throughout the survey, the surveyor was given different information regarding ULP-B's training and start dates. Many of the requested facility documents bore the name of other licensee's and content within were not all applicable to current licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330		
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 infomation: (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	0 650		

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0 650	Continued From page 6 (6) documentation of the background study as required under section 144.057. 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 training and competencies as required by Minnesota Administrative Rule 4659.0190 Subp. 6. for two of two unlicensed personnel ((ULP)-B, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B During observation on March 31, 2025, from 10:17 a.m. to 2:10 p.m., ULP-B supervised residents, provided snacks, did dishes, removed trash, checked blood glucose, and administered medications for two residents. On March 31, 2025, at 11:12 a.m. and 11:49 a.m., ULP-B stated she was new and had worked for a few days and was hired to work full-time. ULP-B stated clinical nurse supervisor (CNS)-A trained her on medication administration, shadowed ULP-E for one day, and completed online training. ULP-B could not give the surveyor an approximate date when she was hired nor exactly how many days she worked on her own since	0 650		

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0 650	Continued From page 7 training. ULP-B was hired on December 16, 2024, to provide direct care and services to the licensee's residents. NO DOCUMENTATION ULP-B's record lacked documentation of the following: -trained on policies and procedures; -trained/competent on Dexcom blood glucose continuous monitoring system; -30-day nurse supervision performing a delegated task; and -trained/competent to set up medications for an unplanned leave of absence. LATE DOCUMENTATION On March 31, 2025, at 1:45 p.m., the surveyor and CNS-A were located in the downstairs office when licensed assisted living director/owner (LALD/O)-D opened the door and stated insulin administration was ready to be given and said because ULP-B was not done with training, she needed CNS-A to come upstairs to assist. CNS-A told LALD/O-D that ULP-B was already trained, and everyone went upstairs to observe ULP-B check blood glucose and administer insulin to R2 and R3. On April 1, 2025, at 9:40 a.m., LALD/O-D provided the surveyor ULP-B's employee record and explained ULP-B's competencies were completed around the first week of March but ULP-B began working last week. ULP-B's Skill Competency dated March 6, 2025, indicated ULP-B demonstrated competency on the following delegated tasks: hand hygiene, personal cares, client mobility, range of motion,	0 650		

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0 650	Continued From page 8 positioning, modified therapeutic diets, oxygen saturation, and general blood glucose testing. ULP-B's Skill Competency dated March 7, 2025, indicated ULP-B demonstrated competency on the following delegated tasks: vital signs (temperature, pulse, respiration, blood pressure, weight), insulin administration, ACE wrap, and medication administration-routes. ULP-B's Skill Competency dated March 8, 2025, indicated ULP-B demonstrated competency on the following delegated tasks: insulin pens. On April 2, 2025, at 3:31 p.m., the surveyor left a voicemail on ULP-B's phone. On April 3, 2025, at 8:34 a.m., the surveyor left another voicemail on ULP-B's phone. At 12:49 p.m., another call was made to ULP-B, no answer. The surveyor did not get a return call to verify training upon survey completion. On April 3, 2025, at 11:02 a.m., via email, the licensee indicated they did not have a 30-day supervision for ULP-B. ULP-E During observation on April 1, 2025, at 8:50 a.m., ULP-E administered oral medications to R2, then checked R2's blood glucose using a different meter and administer insulin. ULP-E was hired on May 17, 2022, to provide direct care and services to the licensee's residents. ULP-E's employee record lacked annual performance reviews and Dexcom blood glucose continuous monitoring system training and	0 650		

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0 650	Continued From page 9 competency. During interview on April 1, 2025, at 11:20 a.m., ULP-E stated she received a performance review about two months ago but could not find it within her file. She recalled signing a form. At 3:00 p.m., ULP-E stated CNS-A trained her on the Dexcom monitoring system. During interview on April 2, 2025, at 12:30 p.m., CNS-A stated she did not have documentation of ULP-B's policy/procedure training, training on Dexcom monitoring system, and medication set up for leave of absence. She trained all staff on how to use the Dexcom system but did not have documentation of that training. At 1:04 p.m., during record review with CNS-A, the surveyor noted discrepancies with ULP-B's start date as the surveyor observed ULP-B's name documented for medication set up for a leave of absence on December 2024. The surveyor asked CNS-A for clarification on the discrepancy and CNS-A was unable to explain and stated ULP-B's above competencies were created upon surveyor request. CNS-A explained ULP-B was trained and competent on all the required tasks but failed to document it. CNS-A stated a staff person who longer worked for the licensee completed ULP-E's performance review and needed to check her email to see if that person emailed it to her. The requested document was never provided. The licensee's 5.02 Competency Training Evaluations policy effective August 1, 2021, indicated a copy of all education, training and competency testing shall be kept in each employee's personnel file.	0 650		

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0 650	Continued From page 10 Minnesota Administrative Rule 4659.0190 Subp. 6 published August 11, 2021, indicated all training and competency must be documented and maintained in each employee's respected record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and	0 660		

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	39173	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISE UP HOME CARE LLC	7207 FRANCE AVENUE BROOKLYN CENTER, MN 55429

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0 660	Continued From page 11 screening within 90 days of hire for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 31, 2025, between 10:17 a.m. and 2:10 p.m., the surveyor observed ULP-B work the shift alone providing resident supervision, snacks, housekeeping, and medication and treatment administration to multiple residents. The licensee's Facility TB Risk Assessment dated June 1, 2024, indicated the facility had a low risk of TB transmission. ULP-B was hired on December 16, 2024, to provide direct care and services to the licensee's residents. ULP-B's employee file included a QuantiFERON(R)-TB Gold Plus TB blood test dated March 21, 2024, with a negative result. ULP-B's employee record also included a TB history and symptom screening tool completed March 21, 2025, approximately three months after hire. ULP-B's employee record lacked baseline testing and screening within 90 days of hire.	0 660		

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0 660	Continued From page 12 On April 2, 2025, at 1:04 p.m., clinical nurse supervisor (CNS)-A stated they dropped the ball on ULP-B's employee record which explained why the TB test was done on March 21 instead upon hire. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated baseline screening was required for all health care workers at the time of hire. The MDH TB Resources and FAQ's webpage, last updated December 13, 2024, indicated each provider licensed by MDH is required to complete a TB facility risk assessment annually. The webpage also indicated all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. Lastly, also required all health care personnel should be screened for TB upon hire and the TB screening process included: - assessing for current symptoms of active TB disease; - assessing TB history; and - a TB test which could include TB blood test or TB skin test. 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	0 680		

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0 680	Continued From page 13 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content in. This had the potential to affect all residents receiving services under the assisted living license. 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	0 680		

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0 680	Continued From page 14 a large portion or all of the residents). The findings include: On March 31, 2025, at 11:45 a.m., during facility tour, the surveyor noted a rambler one level family home with finished basement. The main level had three bedrooms, which two of them occupied and two bedrooms downstairs occupied. The licensee had the capacity of five residents. On March 31, 2025, at 11:02 a.m., the surveyor requested from unlicensed personnel (ULP)-B the licensee's EPP. ULP-B looked around, looked through binders on the medication cart and stated clinical nurse supervisor (CNS)-A might have it or that it was in the locked file cabinet within the office downstairs which she did not have access to. At 11:27 a.m., the surveyor located a colorful plastic hanging file containing the licensee's EPP which was right next to the refrigerator in the kitchen. During interview on April 1, 2025, at 11:15 a.m., the surveyor asked licensed assisted living director/owner (LALD/O)-D if the EPP found in the kitchen near the refrigerator was the entire EPP, she stated yes. The licensee's undated, emergency preparedness plan posted lacked the following required content: -Establishment of the Emergency Program -Develop and Maintain the Emergency Program -Maintain and Annual Emergency Program Updates - Emergency Preparedness Program Patient	0 680		

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0 680	Continued From page 15 Population -Process for Emergency Preparedness Collaboration -Development of Emergency Preparedness Policies and Procedures -Subsistence Needs for Staff and Patients -Procedures for Tracking of Staff and Patients -Policies and Procedures Including Evacuation -Policies and Procedures for Sheltering -Policies and Procedures for Medical Documents -Policies and Procedures for Volunteers -Arrangement with Other Facilities -Roles under a Waiver Declared by Secretary -Development of Communication Plan -Emergency Officials Contact Information (lacked state licensing and MN Office of Ombudsman for LTC) -Primary and Alternate Means for Communication -Methods for Sharing Information -Procedure for Sharing Information on Occupancy and or Needs -Long term care Family Notifications -Emergency Preparedness Training and Testing -Long Term Care Emergency Power (Typically Engineering) During interview on April 3, 2025, at 12:34 p.m., the surveyor asked LALD/O-D again if everything was in the EPP, she stated, no, that she had two binders. LALD/O-D stated she wanted to make sure all current versions were provided so she would email them. They were received by email at 3:17 p.m. The licensee's Emergency Preparedness Plan dated May 2018, included information about a fire alarm system wired directly to the fire station, fire doors on magnetic holders that would automatically close, and a fire panel. The missing resident policy indicated to check the beauty shop	0 680		

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0 680	Continued From page 16 and smoking room within the facility which the licensee does not have. During loss of power, the procedure stated to use emergency outlets powered by the generator which licensee did not have. The licensee's undated [different licensee's name] Hazard Vulnerability Assessment (HVA) included technological hazards, human hazards, natural disasters and overall top 10 disasters. The licensee's undated Mitigation Plans for the Top 10 hazards included a third licensee's name within the mitigated plan for communications systems failure. The licensee's undated Memorandum of Understanding (MOU) between licensee and another licensee, included a name of a third licensee in the first paragraph. On April 4, 2025, at 10:11 a.m., during phone interview, LALD/O-D stated, "I try to maintain it every year," but did not document her review/revisions. LALD/O-D stated the HVA was another licensee's assessment, but the mitigation was for this facility and did not have a HVA available. She indicated the name of another licensee's name should not have been in there. Regarding the MOU, the agreement was between two licensees, not three. LALD/O-D stated the EPP posted was not tailored to this facility as it contained information that was not applicable to them such as having a generator. LALD/O-D stated policy and procedure for use of volunteers, handing medical records, transportation, and more were not included in the EPP and the EPP documents provided via email were normally kept in the locked metal cabinet within the main floor living room which was not accessible to everyone.	0 680		

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0 680	Continued From page 17 The licensee's Emergency Preparedness Plan Compliance policy updated August 2021, indicated the licensee would have an EPP that was aligned with the Centers for Medicare/Medicaid Services State Operational Manual (Appendix Z). The plan is reviewed annually and would include all of the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730		

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0 730	Continued From page 18 (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 observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided and documentation of medication administration was completed for resident who was away from home for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 730		

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0 730	Continued From page 19 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included type II diabetes mellitus, bipolar disorder (extreme mood swings), post-traumatic stress disorder (PTSD), and anxiety disorder. R2's Service Plan (Waiver)-Addendum to Contract signed on October 9, 2024, indicated R2 received medication and treatment management services, safety checks, bathing reminders, bedmaking, behavior management, meal prep, vital sign checks (blood pressure, oxygen saturation, pulse), nurse supervision, and housekeeping. SERVICE DOCUMENTATION R2's Service Recap Summary dated March 2025, included initials of staff that provided services but lacked initials (blank squares) on services throughout the day, evening, and overnight: -March 15 (24 services), March 16 (16 services), March 17 (24 services), March 18 (24 services), March 21 (23 services), March 22 (11 services), March 23 (9 services), and March 24 (3 services). MEDICATION LEAVE OF ABSENCE DOCUMENTATION R2's Med Admin Summary dated March 2025, indicated R2 had a leave of absence from March 25, 2025, at 2:00 p.m. to March 30, 2025, at 9:00 a.m., and medications were put on hold and appeared as an "H" (would not appear on the electronic medication record during that time frame). The summary indicated R2 took the	0 730		

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0 730	Continued From page 20 following medications: Buspar for anxiety, fluticasone propionate for inflammation, gabapentin for pain, Lantus Solostar insulin for diabetes, lisinopril for high blood pressure, metformin for diabetes, multivitamin, Novolog insulin for diabetes, olanzapine for anxiety, omeprazole for acid reflux, propranolol for anxiety, quetiapine for anxiety, sertraline for anxiety, Strattera for attention-deficit/hyperactivity disorder, atorvastatin for high cholesterol, melatonin for sleep, Ozempic for diabetes, prazosin for nightmares, and trazodone for sleep. R2's medical record lacked documentation that above medications were set up and given to resident or resident's designated representative for her leave of absence (LOA). During interview on April 2, 2025, at 10:50 a.m., unlicensed personnel (ULP)-E explained that R2 went to her daughter's house during the LOA and medications were sent with her daughter and there should be a piece of paper the daughter signed confirming medications were sent. She was unable to find the document and referred to management. During interview on April 2, 2025, at 12:57 p.m., clinical nurse supervisor (CNS)-A did not have documentation available for R2's medication set up for LOA and explained that ULP could go to the resident's profile and click the date range of the LOA and could print the medication administration record and have documentation of the LOA that was sent. At 1:04 p.m., CNS-A stated the blank squares on the service recap summary meant services were not documented by staff, but she knew the services were provided. She explained the activity	0 730		

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0 730	Continued From page 21 person they hired was responsible for checking documentation compliance and since that activity person left, the compliance checks have not been completed and was surprised to see the amount of missed charting. The licensee's 2.37 Resident Record - Documentation policy effective August 1, 2024, indicated staff authorized to document in a resident record will do so for all medications, services, treatments, and therapies for each resident. Staff will also document other important and pertinent information relating to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers.	0 790		

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0 790	Continued From page 22 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) 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 April 1, 2025, at approximately 11:30 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-D. The service tag on the portable fire extinguisher in the lower level indicated the last service was in 2023. Portable fire extinguishers shall be inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. On April 1, 2025, the surveyor explained to LALD/O-D that the portable fire extinguishers must be provided annual certification tags and monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD/O-D stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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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 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	0 810		

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0 810	Continued From page 24 safety and evacuation plan with the required content 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 April 1, 2025, licensed assisted living director/owner (LALD/O)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors, elevators, and sprinklers. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39173	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 25 On April 1, 2025, LALD/O-D acknowledged the area that was incomplete and would work to bring the policy into compliance. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted only once per shift and not twice per shift in accordance with statute requirements. No other documentation was provided. On April 1, 2025, LALD/O-D stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with all state and local governing laws. This had the potential to affect all staff, residents, and visitors.	0 830		

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0 830	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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 April 1, 2025, at approximately 11:30 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-D. The surveyor observed new construction in the lower-level laundry room. The surveyor asked LALD/O-D if a permit was issued for the work. LALD/O-D stated the only work being done was painting. The surveyor observed fresh cut lumber and gypsum wall covering material next to the garage matching the construction taking place. Under MN Rules 1300.0120, An owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert, or replace any gas, mechanical, electrical, plumbing system, or other equipment, the installation of which is regulated by the code; or cause any such work to be done, shall first make application to the building official and obtain the required permit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		

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0 910	Continued From page 27	0 910		
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 all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's Resident Contract for Assisted Living lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID) of the facility.	0 910		

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0 910	Continued From page 28 On April 1, 2025, at 1:20 p.m., the surveyor asked licensed assisted living director/owner (LALD/O)-D why there were three different contracts among record review, she explained they had been making changes as she saw fit but did not realize the HFID was not included on everyone's contract. The licensee's 1.05 Signing an Assisted Living Contract dated August 1, 2021, indicated when a prospective resident decides to move into [licensee] a signed assisted living contract signed and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
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.	01290		

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01290	Continued From page 29 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 two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 31, 2025, at 10:17 a.m., the surveyor arrived at the facility and was greeted by ULP-B who was on the phone regarding one of the residents. ULP-B was alone overseeing four residents, and the surveyor observed her between 10:20 a.m. to 12:36 p.m., cleaning a bathroom, sweeping, and washing dishes, provide snacks to two residents, provide smoking supervision to one resident, and overall supervision of all residents. During that time period, ULP-B assisted the surveyor by providing requested documents. The licensee's Daily schedule for March 31, 2025, indicated ULP-B was scheduled to work "AM" (morning) shift.	01290	During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 30 The licensee's Direct Care Staffing Plan reviewed by clinical nurse supervisor (CNS)-A on December 15, 2024, indicated the current staffing model included one ULP per "AM, PM, [evening] and NOC [overnight] shift." ULP-B ULP-B was hired on December 16, 2024, to provide direct care and services to the licensee's residents. The licensee received email notification on March 12, 2025, which indicated the background study fingerprint and photo for ULP-B were not provided in the time required-the entity must immediately remove you from your position. ULP-B's employee record included a Final Registry Results Form dated March 21, 2025, which indicated ULP-B had not been previously determined eligible for employment and must be fingerprinted. ULP-B's record lacked evidence of a cleared background study prior to providing unsupervised services to licensee's residents. ULP-C ULP-C was hired on October 1, 2021, to provide direct care and services to the licensee's residents. A NETStudy 2.0 screenshot dated March 31, 2025, at 3:26 p.m., indicated ULP-C had a Covid-19 expired background study affiliated with a closed assisted living license owned by the same owner as the licensee. ULP-C's background study expired on December 31, 2022.	01290		

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01290	Continued From page 31 ULP-C's record lacked evidence of a cleared background study prior to providing unsupervised services to licensee's residents. On March 31, 2025, at 3:35 p.m., during review of the licensee's NETStudy Roster 2.0 under health facility identification (HFID) 39173 with licensed assisted living director/owner (LALD/O)-D, it indicated ULP-B was "in process," and ULP-C was "N/A" under the "determination" column. LALD/O-D explained ULP-B was scheduled to be fingerprinted after the first background study, but because ULP-B's middle name was not included on the form, she was disqualified to be fingerprinted, so LALD/O-D resubmitted the study. The surveyor asked why ULP-B was currently working, she explained she just started working and was never left alone as she [LALD/O-D] was always on site. LALD/O-D also explained both ULP-C and ULP-E worked at licensee's prior location under HFID 37659, before they moved to current location. After LALD/O-D spoke with the surveyor's supervisor over the phone, LALD/O-D understood that ULP-C needed to be fingerprinted due to the Covid study ending on December 31, 2022. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study has been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position. The NETStudy 2.0 System User Manual updated July 7, 2023, indicated on page 50: Fingerprint Deadline- study subjects who are required to be fingerprinted and photographed in most cases	01290		

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01290	Continued From page 32 have 14 calendar days from the date the study is submitted to complete the process. NETStudy 2.0 users receive email notifications reminding them when a study subject is required to be fingerprinted but has not yet completed the process. Entities are responsible to ensure study subjects are fingerprinted by the deadline. If not, the background study application will close and the entity must submit a new application. The NETStudy 2.0 System User Manual also indicated on page 54: Supervision Status defined as Remove - the study subject must be removed from any position that requires a DHS background study. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Additionally based on observation, interview, and record review, the licensee failed to ensure all employees had a cleared Department of Human Services (DHS) NETStudy 2.0 background study affiliated to the current license for one of one of employee (ULP-E). This had the potential to affect all residents. The findings include: During the entrance conference on March 31, 2025, at 12:13 p.m., LALD/O-D stated she was aware of the required content of the employee record. The licensee's Staff List-By Hire Date dated March 27, 2025, listed ULP-E as a current employee of the licensee. ULP-E was hired on May 17, 2022, to provide direct care and services to the licensee's	01290		

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01290	Continued From page 33 residents. The Department of Human Services (DHS) Net Study 2.0 employee roster dated March 31, 2025, did not include ULP-E as a current employee of the licensee. From April 1, 2025, to April 2, 2025, at various times, the surveyor observed ULP-E working the day shift alone providing supervision, medication and treatment administration, housekeeping, and behavior redirection. On March 31, 2025, at 3:35 p.m., during review of the licensee's NETStudy Roster 2.0 under health facility identification (HFID) 39173 with LALD/O-D, it indicated ULP-E was "N/A" under the "determination" column. LALD/O-D also explained ULP-E worked at licensee's prior location under HFID 37659, before they moved to current location. After LALD/O-D spoke with the surveyor's supervisor over the phone, LALD/O-D understood that ULP-E needed to be affiliated to the current HFID. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study has been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position. The policy did not address background study affiliation. The NETStudy 2.0 System User Manual updated July 7, 2023, indicated on page 82: Add an Affiliation Record-Entities must add study subjects to each of the rosters where the study	01290		

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01290	Continued From page 34 subject is affiliated. This is often referred to as adding an affiliation record and is in lieu of submitting separate background studies for the study subject. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. 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: On March 31, 2025, at 11:45 a.m., during facility tour, the surveyor noted a rambler one level	01880		

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01880	Continued From page 35 home with finished basement. The main level had three bedrooms, which two of them occupied and two bedrooms downstairs occupied. The living room sits at the front of the house, then a medication cart is adjacent to the living room near the walk path to the open stairwell leading to basement and kitchen. The medication cart was placed right next to the side door leading to the driveway. Just beyond the stairwell is the kitchen table and kitchen. At 1:05 p.m., during entrance conference, clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to all residents. On April 2, 2025, at 9:41 a.m. to 9:55 a.m., the surveyor observed the medication cart had a metal button lock that was popped out indicating it was unlocked. The surveyor was moving around during this time but noted it was unlocked every time the medication cart was observed during this time frame. At 10:25 a.m., the surveyor was sitting at the kitchen table doing record review. Unlicensed personnel (ULP)-E was the only ULP working the shift. ULP-E went downstairs and came back up at 10:29 a.m., went to the medication cart, opened a drawer, shut it and left it unlocked. R5 came out of his room and asked ULP-E for a cigarette and went outside. -10:31 a.m.-ULP-E went back downstairs and the surveyor heard sweeping. -10:32 a.m.-ULP-E came back up, put broom away in closet near front door and went into the kitchen. -10:50 a.m. to 10:56 a.m.-The surveyor asked ULP-E some questions and the medication cart was still unlocked.	01880		

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01880	Continued From page 36 -11:11 a.m.-R5 came upstairs (R5's bedroom was downstairs) and began pacing back and forth between the living room and kitchen passing the medication cart each time. Shortly after, ULP-E approached R5 and provided redirection as he was asking for another cigarette. -11:15 a.m.-ULP-E was in the kitchen with her back to the unlocked medication cart and R5 still pacing back and forth. -11:18 a.m.-ULP-E went to medication cart, grabbed her keys to unlock it and realized it was already unlocked, opened a drawer, grabbed a cigarette, gave it to R5, and left it unlocked before walking away. -11:27 a.m.-R5 came up from downstairs and began pacing again, pacing more in the kitchen area and made himself coffee. -11:52 a.m.-ULP-E finally locked the medication cart by pushing the metal button in. During interview at 1:04 p.m., CNS-A stated the medication cart was to be always locked. The licensee's 7.11 Medication Storage policy effective August 1, 2021, indicated medications would be kept securely locked. Only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

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01890	Continued From page 37 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information 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 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: During observation on April 1, 2025, at 8:50 a.m., unlicensed personnel (ULP)-E picked up R2's Novolog FlexPen (fast acting injectable insulin) which had an open date and expiration date with initials of the person marking the dates. The FlexPen did not have R2's name on it nor a pharmacy label. When asked where R2's name was located on the pen, ULP-E pointed at the staff's initials (initials on pen did not match R2's initials). ULP-E explained each person had their own drawer, so they were separate. CNS-A came over to medication cart and observed the insulin pens for R2 and R3. CNS-A used a black Sharpie marker to write full names on each pen. CNS-A explained the pharmacy delivered the pens in a	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39173	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISE UP HOME CARE LLC	7207 FRANCE AVENUE BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 38 box bearing a label, but each pen did not have a label. R2 R2's diagnoses included type II diabetes mellitus, bipolar disorder (extreme mood swings), post-traumatic stress disorder (PTSD), and anxiety disorder. R2's Service Plan (Waiver)-Addendum to Contract signed on October 9, 2024, indicated R2 received medication management services. R2's Med Admin Summary dated April 2025, indicated R2 received the following medications: -Lantus Solostar 100 units (u)/ml (milliliter) (slow acting) injectable-inject 40 units under skin twice daily; and -NovoLog FlexPen 100 u/ml injectable-inject 8 units under skin three times per day with meals. R3 R3's diagnoses included type II diabetes mellitus, bipolar disorder, depression, and PTSD. R3's Master Care Plan dated February 27, 2025, indicated R3 received medication management services. R3's Med Admin Summary dated March 2025, indicated R3 received the following medications: -insulin lispro 100 u/ml (fast-acting) injectable-inject 10 units under skin three times per day with meals; -insulin glargine 100 u/ml (slow acting) injectable-inject 40 units under skin daily at bedtime; and -Ozempic 1 mg (milligram)/3 ml injectable- inject 2 mg under skin once every week.	01890		

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01890	Continued From page 39 During interview on April 3, 2025, at 12:07 p.m., CNS-A stated staff administering medications were responsible for labeling insulin pens when a new one is used. The licensee's Medication Administration-Procedure policy dated August 1, 2021, noted the labels of all medication bottles will be neat and legible. The nurse may never relabel, it must be sent to pharmacy if re-labeling was necessary. The licensee's 7.36 Insulin policy effective August 1, 2021, indicated medications were always administered according to the "6 Rights," right person, right medication, right time, right route, right dose, and right chart/record to document. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	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	01940		

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	39173	A. BUILDING: _____ B. WING _____	04/04/2025

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01940	Continued From page 40 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 received blood glucose monitoring assistance. 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: R2's diagnoses included type II diabetes mellitus, bipolar disorder, post-traumatic stress disorder	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39173	A. BUILDING: _____ B. WING _____	04/04/2025

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01940	Continued From page 41 (PTSD), and anxiety disorder. R2's Service Plan (Waiver)-Addendum to Contract signed on October 9, 2024, indicated R2 received blood glucose monitoring four (4) times per day and daily Ace (compression) wrap application. DEXCOM SENSOR/TRANSMITTER On April 1, 2025, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-E check R2's blood glucose (BG) using a single lancet (needle to draw blood) on R2's finger because CNS-A had not placed a new sensor (transmitter holder that attaches to skin) for R2's Dexcom Continuous Glucose Monitoring System. R2's BG was 132 (normal range before meals is between 80-130 milligrams per deciliter). During observation at 2:00 p.m., it appeared CNS-A applied a new Dexcom sensor to R2's abdomen while sitting in the living room. During interview at 2:20 p.m., R2 explained she received assistance with blood glucose monitoring because she would not remember to complete it. She also stated she began using the Dexcom monitor about a month ago. R2's prescriber orders dated March 25, 2025, ordered Dexcom G6 Transmitter (device that attaches to the sensor to transmit data to display device) to be changed every 90 days and Dexcom G6 Sensor to be changed every 10 days. During interview on April 2, 2025, at 12:30 p.m., CNS-A stated R2's medical record was not updated to include the Dexcom sensor and transmitter change and would update the service	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 42 plan to include those missing components. ACE WRAP R2's Orthopedic Urgent Care Follow-Up Information dated August 13 (no year), indicated use of Ace wrap as needed for comfort. During interview on April 2, 2025, at 2:20 p.m., R2 explained she wore her Ace wrap about once a week but did not have it on at the time. R2's medical record lacked an individualized treatment plan to include a statement describing the services that will be provided and documentation of specific resident instructions relating to Ace wrap application. The licensee's 7.05 Treatment & Therapy Management Plan policy effective August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain a statement of the type of services that would be provided. The policy also indicated the treatment plan would have documentation of specific resident instructions relating to the treatment administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	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	01960		

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01960	Continued From page 43 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 (R2) who received blood glucose monitoring. 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: R2's diagnoses included type II diabetes mellitus, bipolar disorder, post-traumatic stress disorder (PTSD), and anxiety disorder. R2's Service Plan (Waiver)-Addendum to Contract signed on October 9, 2024, indicated R2 received blood glucose monitoring four (4) times per day. On April 1, 2025, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-E check R2's blood glucose (BG) using a single lancet (needle poke to draw blood) on R2's finger.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 44 ULP-E explained R2's Dexcom sensor (transmitter holder that attaches to skin) had expired, and CNS-A had not placed a new one yet. R2's BG was 132 (normal range before meals is between 80-130 milligrams per deciliter). R2's prescriber orders dated March 25, 2025, ordered Dexcom G6 Transmitter (device that attaches to the sensor to transmit blood glucose data to display device) to be changed every 90 days and Dexcom G6 Sensor to be changed every 10 days. R2's medical record lacked documentation of Dexcom sensor change. During interview on April 2, 2025, at 12:30 p.m., CNS-A stated she had replaced the sensor twice since returning to the facility from inpatient treatment but did not document it was changed. At 1:10 p.m., CNS-A stated when R2 returned to facility from inpatient treatment, R2 came with a box containing replacement sensors which contained instructions on how often to replace them. CNS-A stated the pharmacy had the prescription and it took a while for them to get delivered (hence the reason why ULPs were using finger lancets instead of the Dexcom monitor). The licensee's 7.22 Medication & Treatment Record-Documentation & Refusal policy effective date August 1, 2021, indicated documentation of treatment administration would be completed by the person who performed the task immediately after the administration is completed. No further information was provided.	01960		

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01960	Continued From page 45 TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64974
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *03/31/25*
Time: 13:15:17
Report: 8058251074

Food and Beverage Establishment Inspection Report

Location:
Rise Up Home Care LLC
7207 France Ave
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0041032
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TOMATO
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

RESIDENTIAL HOME, NON COMMERCIAL APPLIANCES AND FINISHES

HRD INSPECTOR ANNA BOHNEN

UNABLE TO VERIFY DISH TEMPERATURE DURING INSPECTOR, REQUESTED PHOTO OF LABEL BE SENT VIA TEXT OR EMAIL TO VERIFY SANITIZING ABILITY

ADDITIONALLY REQUESTED A TEMP LOG BE KEPT FOR DISH TEMP

Type: Full
Date: *03/31/25*
Time: 13:15:17
Report: 8058251074
Rise Up Home Care LLC

Food and Beverage Establishment Inspection Report

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 8058251074 of 03/31/25.

Certified Food Protection Manager: JOAN KIBAARA

Certification Number: 20209 Expires: 08/25/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
JOAN KIBAARA
PIC

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
aaron.gertz@state.mn.us