



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 6, 2025

Licensee
Sunrise Of Roseville
2555 Snelling Avenue North
Roseville, MN 55113

RE: Project Number(s) SL21410016

Dear Licensee:

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

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

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,



Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2024
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NAME OF PROVIDER OR SUPPLIER SUNRISE OF ROSEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2555 SNELLING AVENUE NORTH ROSEVILLE, MN 55113
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS: SL21410016-0</p> <p>On December 9, 2024, through December 11, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 62 residents; 62 receiving services under the provider's Assisted Living with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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0 480	<p>Continued From page 2</p> <p>allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		

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0 650 SS=F	<p>144G.42 Subd. 8 (a) Staff records</p> <p>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of three employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-D).</p> <p>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</p>	0 650		

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0 650	<p>Continued From page 4</p> <p>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>CNS-B CNS-B was hired May 19, 2006, and provided supervision to direct care staff and direct cares for residents of the facility.</p> <p>CNS-B's employee record lacked documentation of annual performance reviews that would have identified areas of improvement needed and training needs.</p> <p>ULP-D ULP-D was hired October 3, 2024, and provided direct care for the residents of the facility.</p> <p>ULP-D's employee record lacked a current job description, to include qualifications, responsibilities, and identification of staff persons providing supervision.</p> <p>On December 10, 2024, at 12:00 p.m., business office coordinator (BOC)-F stated she had gone through ULP-D's employee file; however, could not find a current job description with the required content. BOC-F further stated she must have missed providing a job description to ULP-D or it had been misplaced.</p> <p>On December 11, 2024, at 12:50 p.m., licensed assisted living director (LALD)-A stated licensee's regional director of operations was responsible to ensure performance reviews were completed for management positions and would have completed them by March 2024. LALD-A further stated she had been covering two facilities during</p>	0 650		

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0 650	<p>Continued From page 5</p> <p>that timeframe; therefore, she had no time to ensure annual reviews had been completed.</p> <p>The licensee's Personnel Records policy dated January 20, 2020, noted personnel records would include a job description, including qualifications, responsibilities, and identification of supervisors.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 650		
0 660 SS=D	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(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.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers</p>	0 660		

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0 660	<p>Continued From page 6</p> <p>for Disease Control and Prevention (CDC) which included a TB history and symptom screening and baseline TB testing for one of three employees (clinical nurse supervisor (CNS)-B.</p> <p>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).</p> <p>The findings include:</p> <p>The facility TB risk assessment dated December 9, 2024, indicated the facility was a low risk setting for TB transmission.</p> <p>CNS-B was hired May 19, 2006, and provided supervision to direct care staff and direct cares for residents of the facility.</p> <p>CNS-B's employee record included baseline TB test results dated May 22, 2006, and October 15, 2008; however, lacked a TB history and symptom screening.</p> <p>On December 11, 2024, at 12:50 p.m., licensed assisted living director (LALD)-A stated CNS-B's employee record lacked documentation of TB history and symptom screening. LALD-A indicated business office coordinator (BOC)-F was responsible for ensuring employee records included TB history and symptom screening and baseline TB testing. LALD-A further stated she was responsible for auditing employee records and would have noticed the above information had been missing; however, it must have been</p>	0 660		

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0 660	<p>Continued From page 7</p> <p>missed during her employee record audit.</p> <p>The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test.</p> <p>The licensee's Tuberculosis Screening policy, dated September 3, 2021, indicated the licensee would establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). Furthermore, the policy indicated screening would be conducted as follows:</p> <ol style="list-style-type: none"> 1. Team members would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. Team members would have a two-step tuberculin skin test (TST) or a TB blood test, such as the QuantiFERON or the T-SPOT and following the most current tuberculosis infection control guidelines issued by the CDC. 3. No team member would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first TST were read and documented, or a negative TB blood test result was received. 	0 660		

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0 660	Continued From page 8 4. Documentation of TB screening (s) TST/blood test would be maintained in the team member's confidential health file. 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 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	0 680		

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0 680	<p>Continued From page 9</p> <p>by: Based on interview and record review, the licensee failed to maintain a written emergency disaster plan with all required content. This had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's Emergency Preparedness (EP) plan lacked the following required content:</p> <ul style="list-style-type: none"> - a description of the population served by the licensee; - process for EP cooperation and collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: <ul style="list-style-type: none"> - evacuation plan; - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; - a communication plan that included: <ul style="list-style-type: none"> - arrangement with other facilities; 	0 680		

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0 680	<p>Continued From page 10</p> <ul style="list-style-type: none"> - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. <p>On December 9, 2024, at 11:47 a.m., licensed assisted living director (LALD)-A stated the EP plan did not include the required content noted above. LALD-A further stated she was aware the EP plan required a ton of work and had been working on the EP Plan; however, it wasn't completed. Moreover, LALD-A stated licensee had not posted a disaster plan prominently within the facility as required.</p> <p>The licensee's Emergency Preparedness policy dated March 3, 2003, indicated all necessary precautions would be taken to ensure the safety and well-being of residents, team members, and visitors in the event of a national emergency. Furthermore, the licensee's EP procedures would include:</p> <ul style="list-style-type: none"> - conducting disaster drills; - reviewing emergency evacuation procedures; 	0 680		

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0 680	Continued From page 11 - reviewing fire procedures; - regularly communicate current events; - maintaining a 24-hour communications and safety watch if sheltering in place; - manage the food and water supply; and - monitor the Homeland Security Advisory System. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	<p>Continued From page 12</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with provisions of the Minnesota State Fire Code throughout the facility. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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).</p> <p>Findings include:</p> <p>On a facility tour on December 10, 2024, from 10:45 a.m. to 1:35 p.m., with area facilities manager (AFM)-E, the surveyor observed the following:</p> <p>Fire door assembly to third floor elevator lobby had been rendered ineffective. Self closer was not maintained in proper working order and was no longer attached to fire door to pull door closed. Fire door was also painted over, covering information on fire rating. Fire door assembly must be maintained in proper working order and not altered to reduce fire protection.</p> <p>Sprinkler heads were missing escutcheon caps in therapy room, and library on the first floor.</p> <p>Mechanical closets and communications closets on first floor, second floor and third floor had</p>	0 780		

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0 780	<p>Continued From page 13</p> <p>unprotected holes around installed wires which exposed walls and did not maintain fire protection rating. All other openings in these closets had fire-caulking present around openings. AFM-E stated that the noted unprotected holes were due to new electrical wires being installed in place of wires that previously had fire-caulking installed. The fire rating should be maintained.</p> <p>During the facility tour interview on December 10, 2024, AFM-E verified the above listed fire protection and physical environment observations while accompanying on the tour.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 780		
0 800 SS=D	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>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.</p>	0 800		

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0 800	<p>Continued From page 14</p> <p>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).</p> <p>The findings include:</p> <p>On a facility tour on December 10, 2024, from 10:45 a.m. to 1:35 p.m., with area facilities manager (AFM)-E, the surveyor observed the following: The electrical panel near room 107 had empty circuits which were left exposed and not covered properly.</p> <p>Resident sleeping room 331 had a closet that had missing hardware for opening the closet door.</p> <p>Resident sleeping room 331 had a broken outlet cover over an electrical outlet.</p> <p>During the facility tour interview on December 10, 2024, AFM-E verified the above listed physical environment observations while accompanying on the tour.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p>	0 810		

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0 810	<p>Continued From page 15</p> <p>(1) location and number of resident sleeping rooms;</p> <p>(2) staff actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(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.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, and failed provide required training and procedures. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a</p>	0 810		

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0 810	<p>Continued From page 16</p> <p>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).</p> <p>The findings include:</p> <p>On December 10, 2024, at 12:45 p.m., area facilities manager (AFM)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>The licensee's FSEP lacked the following:</p> <p>The FSEP did not include specific employee actions or procedures to be taken in event of fire or similar emergency in the binder. Documents indicated that training on evacuations is provided to staff, but those documents are not included in the FSEP.</p> <p>The FSEP did not include documents on fire evacuation procedures for residents who are capable of self preservation.</p> <p>The FSEP did not include documentation of any trainings offered to residents regarding evacuation or actions to take during a fire .</p> <p>During the record review and interview on December 10, 2024, AFM-E verified the above listed documents were absent from the FSEP.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		

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01470	Continued From page 17	01470		
01470 SS=D	<p>144G.63 Subd. 2 Content of required orientation</p> <p>(a) The orientation must contain the following topics:</p> <p>(1) an overview of this chapter;</p> <p>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;</p> <p>(3) handling of emergencies and use of emergency services;</p> <p>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);</p> <p>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</p> <p>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</p> <p>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</p> <p>(9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.</p> <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this</p>	01470		

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01470	<p>Continued From page 18</p> <p>subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;</p> <p>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include the required content, for one of three employees (unlicensed personnel (ULP)-D).</p> <p>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).</p> <p>The findings include:</p>	01470		

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01470	<p>Continued From page 19</p> <p>ULP-D was hired on October 10, 2024, and provided direct care and services to residents of the facility.</p> <p>ULP-D's employee record lacked documentation the following orientation topics were completed:</p> <ul style="list-style-type: none"> -an overview of assisted living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. <p>On December 9, 2024, at 10:35 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated licensee had used Relias and The Training Channel (online training modules), along with registered nurse (RN) observations, and hands on shadowing to complete staff training.</p>	01470		

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01470	<p>Continued From page 20</p> <p>On December 10, 2024, at 12:50 p.m., business office coordinator (BOC)-F stated she had gone through ULP-D's employee file; however, could not locate the new orientation training material listed above. BOC-F further stated upon hire, all employees attend new hire orientation at a sister facility; however, she had been behind on filing employee documents and could not locate the documents listed above.</p> <p>The licensee's Team Member Training policy dated August 19, 2021, indicated, team members providing and supervising direct services would complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents and training would include:</p> <ul style="list-style-type: none"> - overview of Minnesota Assisted Living regulations chapter 144G.63; - introduction and review of the licensee's policies and procedures related to the provision of assisted living services by the individual team member; - handling of emergencies and use of emergency services (requires competency evaluation for unlicensed team members; - compliance with and reporting of maltreatment of vulnerable adults; - the Assisted Living Bill of Rights and team member responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member; - handling of residents complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility complaints; - consumer Advocacy Services of the Office of Ombudsman for Long-Term care, Office of 	01470		

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01470	<p>Continued From page 21</p> <p>Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, County-Managed Care Advocates, or other relevant advocacy services;</p> <ul style="list-style-type: none"> - a review of the types of assisted living services the team member will provide and the community ' s category of licensure; - emergency and disaster planning; - fire safety and evacuation plans; - the team member ' s job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed; - the community's organization chart and the roles of team members within the community, and the services offered by the community as identified in the uniform checklist disclosure of services; and - the identification of incidents of maltreatment as defined under Minnesota statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01470		
01500 SS=F	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p>	01500		

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01500	<p>Continued From page 22</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated</p>	01500		

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01500	<p>Continued From page 23</p> <p>age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-C).</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).</p> <p>The findings include:</p> <p>CNS-B CNS-B was hired May 19, 2006, and provided supervision to direct care staff and direct cares for residents of the facility.</p> <p>CNS-B's employee record lacked evidence of eight hours of annual training with the following required topics: - review of the facility's policies and procedures</p>	01500		

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01500	<p>Continued From page 24</p> <p>relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <ul style="list-style-type: none"> - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. <p>ULP-C ULP-C was hired November 26, 2018, and provided direct cares and services for residents of the facility.</p> <p>On December 10, 2024, at 8:45 a.m., surveyor observed ULP-C assist R1, R2, and R3 with medication administration.</p> <p>ULP-C's employee record lacked evidence of eight hours of annual training with the following required topics:</p> <ul style="list-style-type: none"> - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures 	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2024
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NAME OF PROVIDER OR SUPPLIER SUNRISE OF ROSEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2555 SNELLING AVENUE NORTH ROSEVILLE, MN 55113
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	<p>Continued From page 25</p> <p>relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <ul style="list-style-type: none"> - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. <p>On December 10, 2024, at 12:55 p.m., business office coordinator (BOC)-F stated CNS-B and ULP-C's employee files lacked the information listed above. BOC-F further stated licensee had not had time to file all the documents in employee files; therefore, was unable to determine if the required information listed above had been completed.</p> <p>The licensee's Required Annual Training policy, dated August 19, 2021, indicated all team members that perform direct services would complete at least eight hours of annual training for each 12 months of employment. The training could be obtained from the community or another source and would include:</p> <ul style="list-style-type: none"> - reporting of maltreatment of vulnerable adults; - assisted living bill of rights and team member responsibilities related to ensuring the exercise and protection of those rights; - infection control techniques including hand washing, the need for and use of protective gloves, gowns, and masks, appropriate disposal of contaminated materials and equipment, disinfecting environmental surfaces, and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer ' s disease, or related disorders; - review of the community ' s policies and procedures relating to the provision of assisted 	01500		

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NAME OF PROVIDER OR SUPPLIER SUNRISE OF ROSEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2555 SNELLING AVENUE NORTH ROSEVILLE, MN 55113
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01500	Continued From page 26 living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for	01530		

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01530	<p>Continued From page 27</p> <p>each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received at least two hours of training on topics related to dementia for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-C).</p> <p>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).</p> <p>The findings include:</p> <p>CNS-B CNS-B was hired May 19, 2006, and provided supervision to direct care staff and direct cares for residents of the facility.</p> <p>CNS-B's record included one (1) hour of annual dementia care training completed February 2, 2024. The record lacked evidence of at least two hours of dementia care training for each 12 months of employment.</p> <p>ULP-C ULP-C was hired November 26, 2018, and provided direct cares and services for residents of the facility.</p>	01530		

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01530	<p>Continued From page 28</p> <p>On December 10, 2024, at 8:45 a.m., surveyor observed ULP-C assist R1, R2, and R3 with medication administration.</p> <p>ULP-C's record lacked evidence or least two hours of training on topics related to dementia for each 12 months of employment.</p> <p>On December 10, 2024, at 12:55 p.m., business office coordinator (BOC)-F stated CNS-B and ULP-C's employee files lacked the information listed above. BOC-F further stated licensee had not had time to file all the documents in employee files; therefore, was unable to determine if the required information listed above had been completed.</p> <p>The licensee's Required Annual Training policy dated August 19, 2021, indicated assisted living facilities with dementia care's direct-care team members would have completed at least eight hours of initial training within 80 working hours of the employment start date and would have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01530		
01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted</p>	01620		

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01620	<p>Continued From page 29</p> <p>as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 14 calendar days of starting services for two of three residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).</p>	01620		

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01620	<p>Continued From page 30</p> <p>The findings include:</p> <p>R1 R1 was admitted October 21, 2024, and had diagnoses to include, but not limited to suicidal ideations, mild cognitive impairment, anxiety, depression, hypertension, and alcohol use.</p> <p>R1's record included documentation of an initial RN nursing assessment completed October 21, 2024, and a reassessment completed November 19, 2024, which was completed greater than 14 days (29 days) after starting services.</p> <p>R2 R2 was admitted May 3, 2024, and had diagnoses to include, but not limited to unspecified dementia, atrial fibrillation, hypertension, urinary incontinence, and chronic kidney disease.</p> <p>R2's record included documentation of an initial RN nursing assessment completed May 3, 2024, and a reassessment completed May 20, 2024, which was completed greater than 14 days (17 days) after starting services.</p> <p>During an interview on December 11, 2024, at 12:36 p.m., clinical nurse supervisor (CNS)-B stated the licensee's electronic medical record (EMR) system indicated a glitch when residents were placed on room reserve; therefore, the 14-day reassessments would not have been triggered as due. CNS-B further stated she was unaware of why reassessments had not been triggered in licensee's EMR system after the initial RN assessment had been completed.</p> <p>The licensee's Resident Assessments, Monitoring, and Supervisory Visits policy dated</p>	01620		

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01620	<p>Continued From page 31</p> <p>August 19, 2021, indicated, the RN would complete a comprehensive assessment prior to a new resident moving into the community and would complete a comprehensive assessment in person every six months, or with a significant change in the resident's condition or needs.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		
02310 SS=F	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for safe storage of oxygen for two of two residents (R3 and R4) using oxygen. This had the potential to affect all 62 residents receiving services under the assisted living with dementia care license, employees, and visitors to the facility.</p> <p>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</p>	02310		

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02310	<p>Continued From page 32</p> <p>or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R3 R3 had diagnoses including, but not limited to, chronic respiratory failure with hypoxia (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide properly) and chronic obstructive pulmonary disease (a long-term lung disease that causes breathing difficulties and restricted airflow).</p> <p>R3's service plan dated November 10, 2024, indicated R3 was on continuous oxygen via nasal cannula at 2.5 liters per minute.</p> <p>On December 10, 2024, at 9:10 a.m., during a tour with unlicensed personnel (ULP)-C, a small green and silver unsecured oxygen cylinder was observed sitting on top of a wooden table, just beyond the hallway entrance, inside R3's apartment.</p> <p>R4 R4 had diagnoses including, but not limited to, acute respiratory failure with hypoxia (a sudden condition that prevents the body from exchanging oxygen and carbon dioxide properly), and emphysema (a long-term lung condition that damages the air sacs in the lungs, making it difficult to breathe).</p> <p>R4's service plan dated October 3, 2024, indicated R4 was on continuous oxygen via nasal cannula at 2 to 3 liters per minute.</p> <p>On December 10, 2024, at 9:30 a.m., during a tour with ULP-C, a small green and silver</p>	02310		

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02310	<p>Continued From page 33</p> <p>unsecured oxygen cylinder was observed sitting on the floor, in the living room, against the corner wall, inside R4's apartment.</p> <p>On December 10, 2024, at 10 a.m., clinical nurse supervisor (CNS)-B stated she was unaware oxygen tanks in R3 and R4's apartments had not been secured properly. CNS-B stated she was going to follow up with the company who supplied the oxygen and ask for oxygen storage racks, or order chains to secure the oxygen tanks to the wall.</p> <p>The licensee's Fire and Life Safety Systems-Fire Prevention policy dated April 4, 2024, indicated small oxygen cylinders for individual resident use would be stored in cylinder holders/racks, signage would be placed on each room that has oxygen stored, and small cylinders would only be used and stored in fully sprinklered areas.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02310		
03090 SS=C	<p>144.6502, Subd. 8 Notice to Visitors</p> <p>(a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."</p> <p>(b) The facility is responsible for installing and maintaining the signage required in this subdivision.</p> <p>This MN Requirement is not met as evidenced by:</p>	03090		

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03090	<p>Continued From page 34</p> <p>Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at all entrances to the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents in the assisted living with dementia care facility, staff, and visitors.</p> <p>This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On December 9, 2024, at 10:15 a.m., the surveyor observed outside the front entrance and just inside the front entrance to the facility. There was no required posting for electronic monitoring devices.</p> <p>On December 9, 2024, at 11:10 a.m., during a facility tour, licensed assisted living director (LALD)-A stated there was no posting at the facility entrance including the statutory language for electronic monitoring. LALD-A further stated licensee had no cameras in use; however, licensee had residents whose responsible party had elected to place cameras in use outside of their apartment doors.</p> <p>The licensee's Electronic Monitoring policy dated September 3, 2021, indicated the licensee would support the use of electric monitoring by their residents and resident representatives (as</p>	03090		

Minnesota Department of Health

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03090	<p>Continued From page 35</p> <p>defined by law). The policy further indicated signs would be installed at each facility entrance accessible to visitors that stated: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	03090		

Type: Full
Date: 12/09/24
Time: 14:30:57
Report: 8058241308

Food and Beverage Establishment Inspection Report

Page 1

Location:

Sunrise Of Roseville
2555 Snelling Avenue North
Roseville, MN55113
Ramsey County, 62

Establishment Info:

ID #: 0038270
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516364800
ID #:

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

The following orders were issued during this inspection.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

CLEAN AND RESEAL THE COUNTER TOP TO THE WALL ALONG THE DISH WASH LINE

Comply By: 01/30/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

REMOVE BUILT UP DUST FROM CEILING TILES ABOVE COOK LINE

Comply By: 01/30/25

Surface and Equipment Sanitizers

Acid: = 700 MLL at --- Degrees Fahrenheit

Location: 3 COMP SINK

Violation Issued: No

Hot Water: = --- at 160 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: COUS COUS

Temperature: 157 Degrees Fahrenheit - Location: HOT HOLDING

Violation Issued: No

Type: Full
 Date: 12/09/24
 Time: 14:30:57
 Report: 8058241308
 Sunrise Of Roseville

Food and Beverage Establishment Inspection Report

Process/Item: EGG DISH
 Temperature: 175 Degrees Fahrenheit - Location: COOKED
 Violation Issued: No

Process/Item: SOUP
 Temperature: 157 Degrees Fahrenheit - Location: HOT WELL
 Violation Issued: No

Process/Item: CHEESE
 Temperature: 41 Degrees Fahrenheit - Location: WALK IN
 Violation Issued: No

Process/Item: STRAWBERRY
 Temperature: 41 Degrees Fahrenheit - Location: WALK IN
 Violation Issued: No

Process/Item: CHICKEN
 Temperature: 41 Degrees Fahrenheit - Location: WALK IN
 Violation Issued: No

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

HRD INSPECTOR RHONDA MAKELA

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 8058241308 of 12/09/24.

Certified Food Protection Manager RONALD FISHER

Certification Number: 60803 Expires: 01/10/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

RONALD FISHER
 PIC

Signed: _____

Aaron Gertz
 Sanitarian 3
 MDH Metro Office
 651 201 4500
 health.foodlodging@state.mn.us